Health Care Cost Trends Hearings

6-29-11 PM

Seena Perumal Carrington

We're going to begin the afternoon session with a review of analytical findings from the Division of Health Care Finance and Policy. First, we're going to look at total medical expense. Steve McCabe, Assistant Commissioner for Health Care Finance, along with Dianna Welch, will be presenting. We're going to take Q&A right after that, so once again, please submit any questions via note card. Members of the division team will be walking around. Then we're going to have a separate presentation from the division on primary care access and supply by Stacey Eccleston, Assistant Commissioner for Health Research and Policy at the agency, and questions after that. Thank you. So we'll begin with Steve.

Steve McCabe

Thank you very much, Seena. I would like to review some of the analysis that the division did related to regional variation in total medical spending. We hope that this analysis might be

useful to help support and inform health resource planning. Chapter 288 required the division to develop regulations governing the calculation and reporting of TME data by Massachusetts insurers. The data presented here is based on calendar year 2009 initial filings.

So what is total medical expense? I know we've gone over this several times. Total medical expenses represent the total health care expenditures for a member population, expressed on a per-member, per-month basis. TME is based on payments for all categories of medical spending, including member cost-sharing. TME also includes non-claims-related payments to providers, such as quality, incentive payments, and capitation risk settlements. TME incorporates health care service type and intensity, such as inpatient or outpatient care, and health care service volume, meaning the utilization or quantity of services, and the price paid to providers for those various services. TME can be measured on an unadjusted basis, which reflects the actual spending, but it does not consider health differences among member populations. TME can be adjusted to reflect differences in member health status in order to better compare spending between different member groups controlling for the difference in member demographics and morbidity. Total medical expense data presented here represents fully and self-insured commercial

members from five large Massachusetts carriers, accounting for approximately 66% of the privately insured market. Collectively, we analyze data for approximately 2.3 million members.

Health resource planning involves ensuring that appropriate health care resources are available to address the health care needs of different regions, communities, and populations. TME data may be a useful metric for comparing medical spending for members of different regional areas and over time, understanding spending trends at regional and local levels. Unadjusted TME in an area reflects actual total health care spending, the result of the type of services members receive, the quantity of services they receive, and the service prices paid for members who reside in that area. Measuring health status adjusted total medical spending at the local level may help identify geographic areas for further study, to determine whether the available health care resources are appropriate, inadequate, or in excess of the health care needs of residents of those communities.

In 2009, total medical expense per member, per month, was $403 for privately insured members in Massachusetts. This chart identifies how that figure breaks out by service category. As you can see, hospital inpatient services accounted for $67, or

17% of spending. Hospital outpatient spending was $97, representing 24% of total medical spending. Collectively, hospital spending accounted for $164, or approximately 41% of total spending. Spending for physician services was $113, or 28% of TME, combined with hospital spending, accounting for nearly 70% of total medical spending. The next largest area was prescription drug spending, at $69 per month, or another 17% of TME. The balance of spending was made up of non-physician professional services, non-claims payments, such as quality incentives and capitation risk settlements, and payments for all other health care services.

This slide illustrates unadjusted actual TME levels in six broad regional areas of the state, and the degree of variation from the statewide TME level of $403 per member, per month. As we can see, there is a range of about 15% variation between the lowest level, $372 per member, per month in Central Massachusetts, to the highest level of $426 per member, per month in the North Shore region. The figures in parentheses indicate the relative TME in relation to the statewide amount. Spending in Western Mass, Central Mass, and the Merrimack Valley are all below the statewide average amount, while spending in Greater Boston, the North Shore, and Southeastern Mass are all above the statewide

level. Again, this data is unadjusted and does not reflect the differing health needs of residents of these broad areas.

In order to compare regional TME while considering the differences in member population, the division developed a ratio which we refer to as relative health status adjusted TME. This was necessary in order to combine adjusted data across carriers, as each carrier used a somewhat different health status adjustment method. To do this, regional health status adjusted TME was divided by the payer average health status adjusted TME to create a payer-specific relativity. These relativities were weighted based upon payer membership in each region, and combined across payers to create a single, aggregate health status adjusted relatively for each region. The resulting health status adjusted relative TME reflects whether, given the payer mix and population of a region, adjusted medical spending is generally at, above, or below spending on a statewide level.

This chart illustrates the health status adjusted relative TME level by region. Here we see that when regional TME is adjusted for member health status, the variation in spending is narrowed to approximately 6% across these regions of the Commonwealth. Central Massachusetts, Western Massachusetts, and the Merrimack Valley remained lower TME areas. Southeastern Massachusetts,

taking into account the health needs of members who reside there, now reflect average level relative TME, while Greater Boston and the North Shore remain higher TME areas.

This chart summarizes the impact of relative health status adjustment on the TME of these regions. The arrows provide the directional impact. A low absolute medical spending in Western and Central Massachusetts appears to be influenced by healthier populations, although spending in those regions remains below the average, even after adjusting for member health status. Conversely, the higher absolute spending, seen in Southeastern Massachusetts, appears almost entirely the result of member health status, as relative TME reflects average health status adjusted spending. In the North Shore, TME remains the highest of these regions, although closer to average after adjusting for health status. Relative TME in the Greater Boston area increased slightly and remains slightly above average after adjusting for health status.

This figure provides data for 335 of Massachusetts's 351 cities and towns, based on data from all five payers in our analysis, covering approximately 2.3 million members. Unadjusted city and towns' TME ranged from a low of $249 per member, per month in one community, to a high of $676 per member, per month in

another community. Again, these figures are unadjusted, and therefore they do not reflect the difference in health status of the members who reside in these towns, but these figures do indicate actual spending mapped to the cities and towns where members reside. The color-coding here is banded in approximately $25 increments around the statewide unadjusted average of $403 per member, per month. There are 77 cities or towns in the highest group, which is indicated by the red bars, with TME levels of $426 or more per member, per month. Sixty cities are in the group that is between the statewide level of $403 and $425, and they're denoted with the darker blue shades -- royal blue, perhaps. There were 198 cities that were below the statewide average, which are in light blue, or in the gray bars.

This analysis looks at cities and towns where Blue Cross Blue Shield reported at least 3,000 members. This threshold was chosen to eliminate any possible distortions in health status adjustment. There were 135 cities and towns that met this criterion for Blue Cross Blue Shield. Across these cities and towns, health status adjusted TME of these members varied by 60%, from a low of $305 per member, per month in Holyoke, to a high of $489 per member, per month in Watertown. Of these 135 communities, 54 cities or towns are in the highest group, at $426 per member, per month, or above. Thirty-five cities are in

the next group, that is above the statewide average, but up to $425. Forty-six cities or towns are below the statewide level.

This slide maps the 53 cities and towns with at least 3,000 Harvard Pilgrim members. Across these cities or towns, the health status adjusted TME of Harvard Pilgrim members varied by 27%, from a low of $353 per member, per month in Lowell, to $450 per member, per month in Brookline. Of these 53 communities, six cities or towns are represented in the highest group, above $426, PMPM; in 15 cities or towns, are in the group that is higher than the state average, up to $425 per member, per month; 32 cities or towns are below the statewide average.

Here we look at Tufts Health Plan. There were 21 cities or towns with at least 3,000 Tufts members. Across these cities or towns, the health status adjusted TME of Tufts Health Plan members varied by 28%, from a low of $337 PMPM in Lowell, to $431 per member, per month in Newton. Of these 21 communities, only one city is in the highest group, denoted in red, as above $426 PMPM. Four cities or towns are in the group that is between the statewide TME level and $425. Sixteen cities or towns are below the statewide level.

This chart lists those cities and towns where, across these largest payers, member health status adjusted TME was either at

or above the payer's average, what we're calling higher TME, or at or below the payer's average, which we're referring to as lower TME. There were 16 cities or towns identified as higher adjusted TME, of which three cities had higher TME across all three payers. Those cities are Arlington, Newton, and Plymouth. Similarly, there were 22 cities and towns where lower adjusted TME across all payers -- and that's health status adjusted. Of these, eight were across all three payers, and they are noted with an asterisk.

This chart maps those 38 cities and towns that we identified as having members with either higher or lower health status adjusted TME across payers. The median health status adjusted TME of these groups varied by 8-13% across the three largest payers. As you can see, there's no obvious regional trend between cities with higher and lower adjusted TME. In fact, in many cases, lower TME cities and towns, and higher TME cities and towns, are in close proximity to one another. In comparing those cities and towns with higher and lower adjusted TME, we mapped 2007 IRS median income data, based on zip codes, to these towns. Based on this analysis, we identified about a 45% difference in median income between the two groups. The higher TME towns were 45% higher in median income than the lower TME towns. To examine this further, we performed regression analyses

to determine if city median income was correlated to health status adjusted TME, and we found a moderate correlation across the three large payers. We explored this relationship by comparing the health status adjusted TME across the 10 most and 10 least affluent communities, based on city median income for Blue Cross and Blue Shield members, as this allowed for comparison across the largest range of communities.

This slide illustrates the difference in median health status adjusted TME between the 10 lowest-income communities and the 10 highest-income communities across Blue Cross Blue Shield members. Again, this looks only at cities and towns where at least 3,000 members reside. As you can see, the median health status adjusted TME for the lowest-income cities and towns was considerably lower, at $382 per member, per month, compared to the median adjusted TME for the higher-income communities, of $456 per member, per month, representing a difference of 19%.

Here, we look at the proportional difference in spending by service category between the highest and lowest-income cities and towns that we just looked at on the previous slide. The proportional spending is quite similar for most categories, including hospital outpatient, physician services, and prescription drugs. Spending varies only slightly for the other

and the non-claims payment categories. However, proportional spending varies significantly for hospital inpatient services, where proportional spending for lower-income cities or towns in 7% greater than for higher-income cities or towns. Looking at the other professional category, we see that spending is proportionally greater for members residing in higher-income cities or towns by 3%, compared to the lower. These differences are due to either the mix or type of services, the quantity of services, the price of services, or some combination of these factors. Further analysis may help identify if access to health resources in these communities is appropriate, given the health needs of these members.

To summarize our analysis of regional total medical expenses, we identified that there are considerable differences in TME by geographic area of member residence. At the regional level, unadjusted TME ranged from $372 per member, per month in Central Mass, to $426 per member, per month in the North Shore region, a variation of about 15%. At least some of this variation is due to differences in member health status. Health status adjusted TME varied significantly across cities and towns of members within a single carrier. Health status adjusted TME varied by as much as 60% for Blue Cross Blue Shield, from a low of $305 per member, per month in Holyoke, to a high of $489 in Watertown.

Health status adjusted TME varied by 27% for Harvard Pilgrim Health Care members, from a low of $353 per member, per month in Lowell, to $450 PMPM in Brookline, and by 28% for Tufts Health Plan members, from a low of $337 in Lowell to a high of $431 per member, per month in Newton. We also found that some cities or towns have lower or higher health status adjusted TME across payers. There's no clear regional pattern which might explain this variation. In some cases, these towns abut one another, suggesting ever finer analysis is required to understand this variation. Health status adjusted TME in the most affluent communities -- was higher in the most affluent communities and lower in the least affluent communities. This again suggests that further inquiry may be warranted to determine whether existing health care resources are appropriate, inadequate, or in excess of the health care needs of these communities.

Thank you very much for your time and attention. If you would like any additional information, please visit our website. Thank you.

Seena Perumal Carrington

Actually, Steve, we've only received one question from the audience related to TME, and I'll ask that now. That is, how much of the variation in TME per town is correlated to the prices of the providers in that vicinity? I.E., Lowell had low TME. Is that partially attributed to the low cost of Lowell in general?

Steve McCabe

I think that price certainly plays a role in this. We did some analysis that looked at the relationship between the hospital service areas and hospital prices. I'm going to ask Dianna to expand a little bit on that.

Dianna Welch

Right, and there is some more information on this in the full report that we put out, but we did look at the hospital discharges and the zip code of the members, and did a correlation between the TME and the relative price of those

hospitals. We did find a moderate correlation between the hospital spending component of the TME and the relative price of the hospitals.

Seena Perumal Carrington

I said there was only one question from the audience and they're coming in. Did any of your analysis take into account other demographic information? Race, economic status, et cetera. Has any of this analysis been replicated using public insurance TME?

Dianna Welch

The only demographic data would have been what's captured by the health status adjustment tools, so age and gender. No, we did not have any data on race or consider that in the analysis.

Seena Perumal Carrington

Did you consider whether the differences in health adjusted TME by income could be explained by low-income people with high-cost

conditions spending down to Medicaid or enrolling in common health?

Dianna Welch

Common care, maybe.

Seena Perumal Carrington

It must be. I assume so.

Steve McCabe

I would say that our analysis looked at the commercial population only. So for low-income areas -- we did, in our analysis, when we looked at those 10 most affluent and 10 least affluent, we ensured that there were at least 3,000 members residing in each of those communities, and we looked at that on a health status adjusted basis, but it did not include an analysis of publicly funded individuals.

Seena Perumal Carrington

Thank you, Steve. Thank you, Dianna. We'll then move to the second presentation on primary care access and supply.

Stacey Eccleston

We heard this morning, actually, about the importance of primary care physicians in delivering quality health care and in being able to coordinate that care. If we're going to rely even more heavily on primary care physicians in the future, then it's important to think about and know about the strength of that workforce in general. This analysis that we're looking at here pulls from a few different sources, existing sources, mostly surveys, to evaluate the strength of this particular part of our health care system.

Several studies have shown that having a robust primary care workforce is important for good health outcomes. The research has shown that there's a strong relationship between the supply of primary care physicians and the overall health of the population, and that states with higher ratios of primary care

physicians to their population have lower rates of mortality from various causes, such as mortality from heart disease, cancer, stroke, and infant mortality. The evidence also shows that a greater emphasis on primary care can be expected to reduce the cost of care, as well as improve those health outcomes, through access to more appropriate services, delivered in more appropriate settings. As mentioned, it's the primary care physician that's central to coordinating patient care throughout the system.

As I said, the data comes from a couple of different sources, three main sources. First, the Mass Medical Society does an annual physician workforce survey. The Association of American Medical Colleges, in its state physician workforce data. We're also pulling from surveys that the Division of Health Care Finance and Policy does on patient access issues. The first two come from surveys of physicians themselves, so directly asking questions of physicians in the state, while the third is a survey of households, asking questions of those households, the experiences that they've had with accessing health care.

The good news, and as we heard -- I think Nancy Kane mentioned earlier that Massachusetts does have more active physicians per capita, as reported in 2009, compared to the rest of the nation,

and in fact compared to other New England states that we're showing here. Now, remember, this is looking at all physician types. At about 407 active physicians per 100,000 residents, Massachusetts is higher than all of the other New England states, and higher than the U.S. average of about 256 per 100,000 residents. You'll note that all of the New England states had a higher-than-average rate of physicians to population compared to the U.S. average. When we look specifically at primary care physicians and the primary care workforce as a percentage of the total physician workforce, we see that Massachusetts is lower than the rest of the nation there, and lower than all of the New England states, except for Connecticut. This means, as a percentage of the total physician workforce, which includes the specialists, the primary care physicians represent a smaller percentage. So more specialists in Massachusetts. Primary care physicians make up just under 32% of the total physician workforce, while, for the U.S., it was nearly 36%.

In fact, only about one-half of the primary care physician offices reported in the surveys that they were accepting new patients, and this was for 2010. Forty-six percent of family medicine or general medicine practitioners offices, and 51% of internal medicine physician offices, so what we consider the

primary care physicians, reported that they were accepting new patients in 2010. This compares to between 80% for pediatric offices to as much as 95% for orthopedic specialities and the other specialities listed here. So about half of our primary care physicians are at their full capacity now. In those offices -- primary care physician offices that are accepting new patients has been on the decline since about 2005. In 2005, 66% of internal medicine physicians, and 70% of family medicine physicians, reported that they were accepting new patients, compared to the 51% and the 46% that we see today, or in 2010, with a pretty substantial drop from 2009 to 2010 for the family medicine practitioners.

There’s also a geographic component to all of this. While overall there were higher rates of active physicians per population in the state, we find that nearly 14% of the residents in the Commonwealth live in what is defined as a primary care shortage area. The Health Resources and Services Administration, HERSA, defines primary care shortage areas as geographic areas where the population to fulltime equivalent physician ratio is greater than 3,500 to one. Or it may be somewhat less than that, but if there’s an unusually high need in the area, or the primary care physicians in contiguous areas are over-utilized or otherwise inaccessible, you can get

designated as a primary care shortage area. Fourteen percent of our residents live in such an area, compared with just 6% for New Hampshire and Vermont.

Perhaps not surprising, from our surveys of the households, we find that about one in five residents reported that they had difficulty getting care in 2010. This varies by geographic area, with those in Boston and in the Western part of the state more often reporting difficulty getting that care. These numbers have been fairly stable over the period 2009-2010. There's different reasons why residents report having difficulty accessing care. In the survey, they can choose from these or get put into one of these categories. They are told either that the physicians office was not accepting new patients, not being able to get an appointment as soon as they thought it was needed, and they were told that the physicians office was not accepting their specific insurance type.

New patients who were seeking care -- and so this is those who answered that the physicians were not accepting new patients -- had more difficulty in Boston, the Southeast, and in the Western part of the state, although there's been an improvement in the Boston and in the Western part of the state for this measure since 2009. In 2010, nearly 13% of the residents estimated from

this representative survey sample reported being unable to access care because the physician offices told them they were not accepting new patients, up from about 10.5% in the prior year. Those figures were just about 8% for MetroWest and the Northeast, and about 10% for Boston, Central Mass, and the Western part of the state, in 2010. For those not being able to get an appointment when needed, there was greater difficulty, again, in Boston and in the Western part of the state. About 21% of residents in the Boston area and 18% in the Western region reported not being able to get an appointment when they felt that it was needed, in 2010, compared to 13-15% throughout the rest of the state.

As far as the insurance type, or being told by the physicians office that they were not accepting that specific insurance type, more residents with Mass Health or Comm Care health care coverage reported difficulty getting care, because the physicians office said they did not accept that particular insurance type. This is looking at the reported health insurance coverage of each of those responding to the surveys, and evaluating their answers to the questions -- if they were unable to get an appointment when needed. Either they were told the provider did not take the particular type of insurance, or were told the provider was not accepting new patients. For the Mass

Health Comm Care group, about 30% of respondents reported difficulty getting care overall, compared with about 17% of Medicare and 22% of employer-sponsored insurance respondents. Medicare patients had less difficulty in most areas here. Fifteen percent of Mass Health and Comm Care patients reported that they were told the provider didn't take their insurance type, and 12% were told the provider was not accepting new patients, compared to less than 10% for the employer-sponsored insurance and for Medicare.

As these findings sort of show, while we do have a strong health care workforce in general, there may be some particular challenges with our primary care workforce, and particular challenges in certain geographic regions of the state, and particular challenges for those who have certain kinds of health insurance. You can find out more information, particularly from our survey, on our website here. I invite you to visit that if you'd like more detail from that survey.

Seena Perumal Carrington

It doesn't actually seem like we have questions from the audience, so why don't we actually move to the next

presentation. I'm pleased to introduce Cathy Schoen, Senior Vice President from the Commonwealth Fund, to talk about how we can think creatively about the health care system we need for the 21st century. Cathy?

Cathy Schoen

Hi, I'm delighted to join you. As you'll see, I'm going to move through some of this presentation quite quickly. I put a bunch of slides in to be on the record to make some points, but I will be talking off of them fairly quickly. I'm going to move away a little bit from what we traditionally think as resource planning, which I think of as Certificate of Need, particularly worrying about the growth of high-cost, potentially duplicative areas where the market is yielding up results that we don't necessarily want, or even headcounts of population ratios or providers-to-population, to really be talking about taking a whole system view, with a view of the kind of health care system we want. I think we're increasingly seeing that new ways of working and re-engineering the way we work together, both what a primary care doctor does in conjunction with a nurse, with a nurse's aid, how doctors work with specialists across sites of care, spanning to think of community care and long-term care,

produces a very different sense of what kind of workforce and what kind of resources, and how we use those resources, are going to be in the future, if we're smart about it and we really think of the tools that are available to us.

So I'm going to focus on five areas. As I said, I won't be as facilities-focused. I think that you have a state -- we have a state -- I live in this state, in Western Mass -- that is doing a lot to look at facility, bed counts, ambulatory surgery, and some of the drivers of cost, so I want to focus on these other five areas: primary care teams, care systems, the potential of much more creative use of information technology, and I'm not talking just about electronic records. Ways of thinking about sharing resources that not everything has to be within a particular practice or even a set of walls. We can have more virtual systems with much more economical and efficient use. Thinking about resource planning implications of that. Then I'll just spend a really short time on payment, because I realize most of the last few days has been on payment.

I said at the beginning, I think that it's important that we're thinking about this with a whole system view. That we want the population to have access to high-quality care, with a focus on improving health, and in a way that's affordable and sustainable

into the future. It’s not just now, but where do we want to be in five years, where do we want to be in 10 years. If we think about this strategically, it’s improving access and thinking of multiple points of access, multiple ways of getting access. We’ve been fixated on visits for years, and we’re increasingly seeing there are other ways of having care be accessible and linking up, and I’ll provide some examples of that. Improving quality, but we can drive down unit costs and we can drive down the units we use if we think much more creatively. We’re redesigning around the patient, spanning across the care system, instead of the silos. I think this requires a vision that’s very much population health-based and driven on what are the population health needs, and what would happen if we kept the population healthier, to the way we use our resources and where we need to put them. It’s a lot about continuous improvement.

I want to just go quickly through some slides that are very similar to some of the things you just saw, but these are from national surveys that the Commonwealth Fund has sponsored, and we do some international work, so I’m going to be bringing in international examples. If you think about access to care from a patient perspective, it’s getting in quickly when you need to get in. It’s also being able to get through to someone by phone when you have a question. It’s what happens to you between six

o’clock and eight in the morning, where -- we call it after-hours care, but most people don’t think in terms of planning for only in-hours care. You get sick at 10 o’clock at night, and where do you go? Is there a care system for you other than the emergency department? It’s not necessarily emergency, but it is care. We’ve got about 70% of the general population saying one of these things has been a problem in the last few years, so thinking broadly about where the points of access could be improved is important.

We fail, quite often, on coordinating care. Handoffs -- information doesn’t flow from primary care doctors to specialists, back again. Patients get delayed information. In fact, some of the malpractice suits we’ve seen are on lab tests where you just never heard the results. We find that the U.S., when we look at it in comparison to other countries, is particularly bad on coordination issues. No one contacts you. No one follows up. We’re doing some of these in sicker populations as well. This is a general population, some of whom had very little contact, but we’re getting half of the population saying one of those things happened to them.

We also get, from a population perspective, the sense that things just aren’t very well organized. “I spent a lot of time”

-- it’s patient resource of time. “I’m going back for a repeat visit because my tests just weren’t there when I showed up. The paperwork wasn’t done. I’m doing two visits, things I think I could have done in one. Why couldn’t I just phone for some of this information?” And a sense that it’s not well organized, some of which is insurance-related, but we also see a care system side. So I think as we’re thinking about a care system, we need to think about flows and how resources work together. I want to focus just for a short amount of time on primary care, but primary care embedded in a care system. Not as isolated practices, but thinking about what are the linkages with primary care practices. Within the care team of the primary practice, how are they linked to specialists, to mental health? How are they linked to long-term care? So it’s embedded in a care system, with a vision of, if we reorganize care, can’t we get more out of the resources we have by using them smarter and using them in different ways? I think those of you who have paid much attention to primary care have all seen a chronic care model that was developed by Ed Wagner, but as you look closely at what is in this larger model, it’s got community care resources in it, it’s got engaging patients. It’s got primary care as a foundation, but it’s embedded in a larger system, so it’s not all by itself. When we’re counting, I think even primary care to population ratios, knowing who’s on that care

team and how they’re practicing, people are seeing very different ways of managing panels. How sick a panel is. We’re seeing different ways of being able to take care of the healthy part of the population differently so we can focus on the sicker.

There are multiple models of what is being called medical home or health home. I’ve just put some pictures up here. Every single one of these is a care system. When you get underneath it and you look at the interactions at the practice level, or at the practice level when working with the hospital, when working with the nursing home, when working with patients when they’re home, there are incredible variations. We’re really in the midst of learning a lot about resource use, new use of people. People working to the top of their license, but also working to the top of what they can do as skills, where the license might actually restrict them. So it’s a very different use and a thought of how nurses work together with physicians, how nurses work in care teams. The most recent research we have that’s coming out of this is dramatic results. Reductions in initial admissions to hospitals, readmissions, reduced use of the emergency room, increased satisfaction, increased patient outcomes, much better patient outcomes. This is not, you just supply this model and it’s magic. These are team systems, and most of them are

finding, as they roll them out and learn and change -- and I'll come back to this refrain at the end -- they change the way the primary care practice is paid. It's not so much the level of payment, but the way they're paid, to enable, facilitate, and encourage this kind of different way of approaching care. They get these kinds of results. Those of you who can or cannot read these, these are all available as public documents. When you get into them, some of it's working with very frail elderly. Some of it's working with healthy populations, low-income populations. The approaches have been tailored to those population needs. Some involve more community outreach and some do not.

One care system in rural Pennsylvania, known as Geisinger -- and I'm just putting Geisinger up because one of the things I think that's very interesting that they're learning is they started it within their closed system. It was part of re-engineering generally their patient navigators, but it was an investment in primary care that they hoped would pay off, and they got this dramatic reduction in hospital use, in ED use. Actually, it's created some friction in some of the communities because there's less need for beds. It's a question of which hospitals and how did they create still an urgent care capacity in some communities as they start -- they have to rethink what is the

capacity that needs to remain to still deal with this. What's been interesting is they've rolled it out to practices that weren't embedded in the Geisinger system, and they're learning different ways of applying a similar philosophy, and how important is it to have a care system that feeds back information to the primary care practice versus a freestanding community health center or practice. I think we're going to be seeing some innovations that come out of these systems as they start to spread and evolve more. The Fund is going to be studying this roll out, because they're rolling it out to practices that aren't used to being part of this care system. They're getting similar results, but it's being applied differently. They can't all just say, here's the model, and bring it down.

In New York, the VNS system has a couple of more managed care products. They're being paid differently. But they're taking care teams with very frail Medicaid patients, but also Medicare patients, focusing on the long-term care side. These are all patients that need home and community case care, need a lot of homecare. The care teams that they put together have started to work closely with the primary care doctors, often conveying information to them that they never knew about their patients. They've started getting into what medications people are on,

what are the patient preferences, and found that that had just never been communicated very well. They've become a resource to the primary care doctors. These are virtual. They are not working together. They're just parallel, and it becomes tighter and tighter virtual networks of primary care and some specialists with these care teams. With, again, quite dramatic results in terms of reduced complications, reduced use of more expensive services, and very high satisfaction ratings of the patients, because the preferences will be met in a much more person-centered care.

Throughout all of these systems, when you look closely at what's happening, there's a role for new information systems. I think this is one where the capacity to learn as we roll these out is just dramatic. These are tools that we didn't have in the past. It is really the twenty-first century tool and breakthrough. To start thinking of, if we have these tools, how do we use them well? How do we embed them in care systems? And thinking beyond just an electronic health record. I'm putting up a slide that Mass General used when they were talking to the Commonwealth Fund board. Aside from what Mass General is doing on some of their re-engineering, I yellow-shaded all the places data systems appear. The data systems appear as new ways of patients and physicians getting in. New web portals. You can

get through to your physician by email, and you can get an answer back by email. The physicians can talk to each other by email. They can get on a web portal and get all the information. It's a portal of access that's quite different than what we've seen before. Kaiser, out on the West Coast, is getting to the point where some of their young, healthy adults, they say, we don't really want to visit you. If we can be in frequent contact and you can answer our questions -- and in some cases, we just upload a picture of the rash, and you tell me whether that's poison ivy or if it's something more. The young adults, they're handling them in a different way. So it's a different portal. You need a care system that can support that. The electronic health record with decision support is also talking about, let's get some protocols in, early warnings. Things aren't working together. You've missed something. The patient never actually followed up on that visit. We have no record that they ever did it. But they're also using it as feedback systems. Where are the benchmarks of things working very well? It creates a learning organization. All these different areas is a potential to actually work quite differently together, even within a hospital or a care system.

Out in Texas, Parkland Hospital is a public hospital, and it has a fully integrated electronic health record. They said, we've

observed these extraordinarily high rates of readmission, and if we try to look at the potential risk of a readmission the day the person walks in our door, at the point of admission -- let's look at what the risk factors are. Most of the literature has talked about the medical risk. They said, we actually know about their social risk. We know about people that are living alone, in a five-story walk-up. That their address has changed all the time. That there's no phone number of anyone near. We know about alcohol and drug abuse. If we factor that in, they're able to create these -- what I've showed you is quintiles of the highest-risk group. The highest-risk group has a readmission rate of 60%, for congestive heart failure. Many of them come back. But underneath that, there are all sorts of reasons that they're at risk. What Parkland is doing is saying, let's be really smart about resources. This person needs the very best home health care nurse we've got right away, because the problem is the home situation. This person has a very unstable heart. That's the problem. They need an immediate visit with the cardiologist. So it's a patient-centered resource allocation. In the first five minutes, they dropped the rate by 30% in the highest-risk group. This highest-risk group accounted for nearly 70% of all their readmissions. They're rolling this out to seven other hospitals, with predicted algorithms, so that they'll be in suburban neighborhoods. It's trying to use this tool as a

resource planning and getting ready in a very different way than I think we've seen before. It's not just risk prediction, but it's thinking of the resources. What's been interesting in Parkland is the physicians have started saying, my patient didn't get the highest-risk group; I think they are. Because on day one, the physician was having the pharmacist come into the room, and someone else come into the room and say, I'm ready, I know what's wrong with your patient. They say, we really want this new way of delivering care.

Internationally, when we look at other countries, some of the information systems they've built, and it's because they're less fragmented than we are as an insurance system -- they have more continuity -- they've, for years, taken a whole population set of metrics. They can feed it back as information to their care providers. They have registries. They have claims data that has information on you from the time you were born until now, but they can actually look at lifetime kinds of risks, and start identifying pockets of risk where they want to put new resources. They use it as a resource planning tool. I'll give you some examples of this just in a second, but I just want to show you that they've also been ahead of us, although I think we're going to be catching up, on the way they've used electronic health records. In Denmark, they've ramped up. They

just keep adding features. Their primary care doctors and specialists all can communicate with each other by email now. They can all communicate with the hospital, with (inaudible). They do email consults, they do email visits, they do email referrals. One of the things they're starting to (inaudible) is this information system is feeding back to them where they have potential drug problems, what things are working well. So they're using it as an information resource as well as communication.

I just couldn't resist putting this picture in. One of my colleagues took a picture of a Dutch doctor's office. The next day, when he got home to the United States, there was a picture of a U.S. doctor's office. They really, in Denmark, have gotten to paperless offices. When you talk to some of the Danish doctors, but I also saw it in the Dutch doctor's office, this has enabled them to free up their receptionists, their medical assistants, in a very different way. They're not spending a lot of time looking for the paper. They're actually arranging the doctor's office visit to be more productive, because they can go in and be partly analysts. This is a patient that's a no-show frequently. This is a patient that needs the following things. They're using their support staff in a new way, and the doctors talk about, as they learn how to use the system, it's less time

for them and it’s more time with the patients. It’s an interesting evolution, but they’ve been rolling it out for years.

In these international examples, one of the things I keep hoping we’re going to see in the United States is more use of population registries. We often will talk about them with a cancer registry or a diabetes registry, but we’re also seeing in other countries is they’re using them as safety warnings. There was a New York Times story in the business section this Sunday about a hip joint replacement that’s metal on metal, that we’re just discovering now that it’s out and lots of people -- it doesn’t work. Not only does it not work as hoped, but it’s putting people at risk. Australia has a registry that tracks this, and they were sending the U.S. early warnings a few years ago, saying, we’re going to start pulling these devices; they’re a risk to us. It’s a different kind of resource. Some of the other countries are taking patient-reported outcomes and putting it as part of the registries. You had cataract surgery; can you see? Are you in pain? Thinking of patients as part of our resources. What it’s done is it’s been an improvement impulse. Wherever there were pockets that weren’t performing as well, two years later, they improved. Providers are extremely competitive. If they weren’t getting as good results, they would like their

patients to do well. This feedback system, Dartmouth is using it, and (inaudible) just developing these, so I think it’s new tools.

Telehealth. Seeing as though we don’t have much of that here in Massachusetts -- you might have it in your VA system, because they’re using it across their system -- but telehealth and e-referrals and e-specialist links are starting to be used by a lot of care systems. There are multiple ways. It’s a communication with patients. It’s with patients at home. But it’s doctor-doctor communications, and we’re starting to get reports back of the specialist being a consultant and coach to the primary care doctor, conveying information. Avoiding two visits to the specialist because the referral says what’s needed. The specialist preorders all the tests they’re going to want, so when the patient comes, it’s one visit rather than two. They’re seeing a different use in these linkages as extremely powerful communication devices that link people together. I’ve just put a few examples, because we’re starting to learn from the VA effort to link out to patient homes with telehealth, but it’s being used in Tennessee. There are a lot of states that have shortage areas. There was actually recently some talk about a Johns Hopkins physician, telehealth being the consultant for a patient in upstate New York. It’s not just rural, rural areas,

but with scarce specialities that really are working at the top of their craft, using resources, not thinking of state lines as confining. That we can get the best of the expertise.

Just a few words about sharing resources. You have one excellent example here in Massachusetts. We often think of resources as being within a set of walls, and I think we're increasingly seeing that we can create virtual systems. Vermont is trying to do community care teams that are more based on the population, but they work with practices, and practices think of them on our team, even though they're not sitting there every day. The early reports from Vermont is it's made a world of difference from solo practices, small practices, who don't have the patient volume to do the high-intensity work with chronic disease, but they have some patients. It's sharing a resource. There are other models of this rolling out in other parts of the country. In Massachusetts, we did a profile of one example of this that I actually heard about from a pediatrics friend in Western Mass, who said because of the Child Psych Access Project, she was practicing pediatrics totally differently. She had started taking care of mental health conditions. She used to refer -- and she actually couldn't refer them easily, because there was a long waiting time. But the specialists had become consultants to her, and she's learned how to do their things, and the families

are delighted. I think it’s a very different way of primary care positions and specialists -- in this case, behavioral health, mental health -- working together.

Internationally, we see some shared efforts to build after-access capacity -- after-hours access capacity -- through use of cooperatives, where it’s not every practice figuring out, how do I do my after-hours care, or only closed systems that know how to do it. I’m just going to show you -- I’m going to focus on the Dutch system, because every time we do an international survey like this, Netherlands looks great. Their patients say, we get in really fast; I’m seeing teams; after-hours care, no sweat. The question is, can you be seen by someone without going to the emergency room? It’s not just, I can get through to someone by phone. You get a very strong response that this primary care system, or that access system, is 24-7. We recently had a presentation by a Dutch doctor. I said, “What are these cooperatives like from a practice level?” What they’ve done is all the community practitioners rotate through the cooperative. They’re paid for their time. They’re often staffed by a nurse. Sometimes they’re colocated in a hospital, but it is not an emergency room. It’s a primary care practice after-hours. They link them with electronic health records, so the next day, if it was not your patient, it’s someone else’s patient, they know

exactly what happened that the patient was visit. The Dutch fellow was talking about this. He put in a picture of his car. They do home visits. They do little scoot-around times. We don't even think of this in the United States anymore, but he showed a metric. They said that the time from call to visit was less than thirty minutes for a home visit. They're measuring the response time on the phone in minutes, in terms of getting to see someone. Now, some of these are resolved by phone. It's, can I change my prescription? I don't know what to do. It's just someone calling for, I've got a question; what should I do? Some of them (inaudible). The Dutch have among the lowest ER use that we've seen in any international country, and very good outcomes for chronic care. So it's an innovation that I don't think we think about, but they think of it as a shared resource. This is everybody's cooperative. This was done by state legislation. It didn't just happen -- it wasn't thrown out by the marketplace. The care system part of it is supported. The doctor's time is then paid through the amount of hours. All of their after-hours went down, by the way. They do much less on-call. The doctors are happier. They go off-duty at 6:00 at night. They come on at 8:00 in the morning. They know exactly what their day is going to be like, and they know when their shared call is. I think we have multiple models of this idea of

sharing resources, or community resources, that are resources we tend to under-value, but they often hold the system together.

Just a little bit on the more traditional health resources strategic planning. Seena said, “You’re sending me a set of slides and it doesn’t talk about anything that anyone normally talks about on health resource planning.” I think there are real implications when you’re thinking about resources. Part of it is that when we think about primary care, you’ve got to be thinking about teams. Not just doing headcounts of physicians, but talking about where are teams growing, how can we handle -- with a similar resource mix, can we make care more accessible for patients? Can the primary care scope of practice actually expand? It’s hard when you’ve got an excess supply of specialists, potentially, but what Geisinger has said is they’ve got primary care doctors doing some things they didn’t used to do before. They used to refer out. Because the doctor’s time been freed up. The team is spending more time with the after-hours consultant. Sharing resources -- the education and training for this is a major hurdle. These are not typical nurses. They’re not aids. The primary care doctors are learning -- they’re learning organizations. Some of it, I think, is going to be on-the-job learning, and then how do we take what people are learning on the job and get it back into our education

system so people are taught to think differently. Think in terms of a population health planning. Thinking about shared resources as a resource, rather than say, oh, yes, we also do that, and examining where there's a potential to [tie?] care systems [to better?]. Scope of practice loss, delegation, who can do what, when, in a more controlled, accountable environment, starting to be freer on those, but how do you keep care systems accountable? So it's not allowing everyone to bill under a new license code. These are very tight teams. They're often paid by salary, so it's not a fee-for-service model, but thinking very differently.

Then, last but not least, trying to bring community health and population health back in. When we get outside the silos of, it's a medical care system, but saying it's a health care system, there are opportunities to intervene in the community that then affect the way we use our resources and the way we plan our resources. I'll give you just one example from within Massachusetts. A colleague of mine was using these in an Australian talk, actually. One of the points he was saying, he said, teamwork is not always easy. It's having people play very different roles than they used to play before. It's talking with each other in a different way. It's a balancing act and it's a learning act. He found these lovely little animal pictures. It's amazing what you can learn to do, and what you can do next

year is different from what you can do now. So not thinking of this as a fixed resource, but it’s a creative resource and we’re learning as we go.

In Alaska, because of shortages, and this is just one example on licensure issues, they said, we’re never going to get a dentist to move to a town that has 120 people total, and you can only get there by dogsled or by helicopter coming in. They’re just not going to go. The tribes, in particular, said, we still want to have dental health access. They trained dental techs. They work under the license of a dentist. They’re teaching them how to drill and fill, as well as hygiene, and they’re getting fabulous results. They have a limited scope of things they’re doing. It’s new training programs. They’re getting access and they’re getting much better oral health. There’s been official federal evaluations of this, as well as local evaluations of it. It’s not just a freestanding practitioner. They are often connected directly with a dentist. They go through intensive training programs. It’s screening for people who are very good with their hands. They’re not necessarily doing root canals. They’re doing the simpler. hey brought this out and they’ve linked them with care systems. They bring patients in when it’s beyond the capacity of local. North Dakota is doing it with pharmacy techs in remote areas.

Children’s Hospital -- I pulled down this, but you’re going to hear later from Cambridge Alliance that they’ve also looked at this. Looking at asthma and saying what’s happening out in somebody’s home makes a huge difference. We don’t have a business model that supports these kind of efforts, but whenever we change the way we pay and we think as care system, people start to look in this direction. It’s happening citywide in Cincinnati, as Children’s Hospital starts to look at it. We should be able to get to the point on diabetes and asthma and some of these chronic conditions that we think of the hospital as the rare event rather than as part of the care team because we prevent the complication.

Last, I’m just going to close down with a short piece on the payment system. The payment reform and multi-payer coherence really matters a lot if we want to use our resources more creatively, if we want to allow innovation to flourish. If we overpay and then try to regulate the use of those resources that make money, it often doesn’t work very well. If we don’t pay in the right ways, that give people incentives to think across their silos, we won’t get the results we want. Reforming the way we pay, not just the level that we’re paying, but the way we pay, is critically important. In every international system, and

some of the results on what primary care matters came from these international studies, they don't pay their primary care doctors the way we do. They pay a per-person, per-month population-based fee, as well as fee-for-service. It's a blend, because they want people to say yes to that next visit. They don't want them to say, I'm sorry, I close at three o'clock in the afternoon. What those different payment systems have allowed them to do is they can build in added amounts for teams. They can (inaudible) added amounts for registries. Then, in a few areas, I think what is particularly interesting, if you think of high-risk, low-income areas, if they have practices that are in very high-need areas -- highly sick people with very low incomes -- they actually do a disparity enhancement to the per-member, per-month. They say, that practice may need translators. It's what we've always done in community health centers, but they do it to all their doctors. They want people -- you may need translators. You may need to take more time because you've got a higher burden of chronic disease. They literally have a disparities index on the community. It enables practices to locate there and know there's going to be a different way of being paid, recognizing that patient mix. So it doesn't apply to very many, but it really moves into inner cities, in immigrant areas, and says there's going to be more time involved.

Changing the way we pay avoids this sense of my revenue base and starts to allow us to move resources out of one revenue base to another, to start thinking about getting away from the tyranny of a visit. That it's OK to talk to someone on the phone, do group visits. You don't have to have billable. You can spend time. You can allocate it differently. It really is quite important, because otherwise we've got people on a treadmill to make the practice of business case work. They're practicing in a way they don't want to. Geisinger, to just use one example, retold on some acute care. They bundled up 30 days post-admission. They rolled it out for a few conditions initially. But in with this, they re-engineered care. They challenged everyone, from before admission to post-admission, what's going wrong? What can we do better that avoids complication? How do we practice at the very top of standards? They've been getting these dramatic results in terms of better outcomes, and they're now rolling it out to increasing number of procedures. One of the things it allowed him to do is think about transition care and linkages with post-acute. They got to know who their nursing homes are. They got to know who they were discharging. They've started having a primary care nurse who's on the primary care chronic care team start to go to the nursing home, and say maybe we can bypass the hospital. Sometimes my patient needs to be

stabilized. But it’s not the hospital, it’s the nursing home. It’s a very different way of thinking.

Complexity, not having everyone on the same page, undermines incentives. If one pays this way -- methods -- versus another, you undermine the incentive of a movement. It also breeds a lot of overhead cost. We have transaction cost buried in every part of our care system, with layers of administrators, or clerks, or senior vice presidents, that are dealing with the fact that everyone does something a little bit differently. You particularly hear this if you get a foreign skilled person coming and working in one of our hospitals. They talk about there are more people here, but there are not more people in the front line. I just see more people. It’s not just billing and payment, but it’s also the way we regulate, and thinking of we all do things a little differently.

Pulling it together, I think payment is extremely important. Being on the same page. If we’ve got market incentives that encourage oversupply of services we don’t value, or undersupply of others, it means we’ve got the incentives wrong. So it’s the level and the way we pay. You’ve got to pay attention to those, because I don’t think you can just regulate them out of existence. So realigning it with the care system we want. I’ll

just close with where I started. I think it’s important to take a whole system view. Thinking about health resources beyond the facilities. Starting to think about our workforce resources, how they work together, what are the support utilities, such as IT and information systems, that we support teams with, will make a huge difference as we move forward. Thank you.

Seena Perumal Carrington

Thank you, Cathy. We’re actually doing very well for time. Given that all the panelists are here, I actually think we should just move to the next portion of our agenda, which is the panel discussion. If I could call all of the panelists to the front of the room, please. Sorry, you took your seat already, but I actually have to ask you to stand for a quick minute while we swear all of you in. Raise your right hand. Do you solemnly swear that the testimony you’re about to give, in the matter now of the hearing, will be the truth, the whole truth, and nothing but the truth, so help you God? Please identify yourself by raising your hand if your testimony today is limited for any reason, if there are any restrictions placed on the capacity in which you testify here today, or if you have any conflicts of interest that require disclosure. Let’s begin.

Actually, we're going to begin with five minutes of opening remarks from each of the panelists, and then we'll move into the Q&A portion of the segment. We'll start with James Hunt, who is Executive Director of the Mass League of Community Health Centers. Thank you.

James W. Hunt, Jr.

Thank you, Commissioner. Hello, everybody. Thanks, Cathy Schoen, for setting the table, if you will. It allows me to cut some of my remarks, because community health centers, as many people in this room know, started here in Massachusetts at Columbia Point in Boston, and have grown to 52 health centers strong, serving over 800,000 people in our Commonwealth. We work with the Commonwealth of Massachusetts. We work on prevention and promotion. We're located in some of the state's most neediest areas. As I always like to say, if you've seen one community health center, you've seen one community health center. We work with the state on a wide range of issues, including the patient-centered medical home, emergency preparedness, and response to public health threats, like seasonal flu and H1N1.

In addition to providing traditional medical care, and partnering on public health issues, community health centers offer an array of accessible services, such as dental, behavioral health, eye care, and so many more, as well as our now burgeoning onsite pharmacies. We administer prevention and wellness programs, heavily engaged in emergency room transition activities, sponsor nationally-recognized programs to help the chronically ill manage their diseases, such as diabetes, asthma, depression, and hypertension, and are increasingly involved in primary care workforce education. A footnote should be that this particular college, Bunker Hill, should be applauded for its tremendous work, particularly with community health centers and formulating career tracks toward real jobs in communities. Kind of an unidentified engine of economic growth in our communities. The Bunker Hill Community College works directly with East Boston Health Center, taking East Boston staff and training them to be registered nurses, with campuses onsite and at the health center. Our professions and paraprofessionals assist patients with health education, applying and maintaining their coverage, locating safe housing and food pantries, obtaining job training, and accessing general social services and needed specialities across the Commonwealth. This approach to comprehensive care provides results. According to a

literature review recently released by the National Association of Community Health Centers, Medicaid patients are 11% less likely to be hospitalized, and 19% less likely to use the emergency room for avoidable conditions if they are community health center patients.

Through the broad-based community boards of directors, centers take a broad view in addressing the long-term needs of communities. We provide critical entry-level jobs and training and career-building. The testimony, the written testimony, which is online, of Frederica Williams, [Frances Anthes], and [Jay Breines] provide additional insight into the challenges faced by and the success of community health centers in our state. Health centers can play an equally important role in addressing the state's primary care provider shortage, which is expected to become more severe as we move toward payment reform. With adequate resources, community health centers are in a strong position to provide the residencies, rotations, and teaching experiences physicians, nurses, and others will need to expose them to increasing innovations in primary care and attracting them to our practices. It's no secret, on the financial side, that health centers generate significant savings to state Medicaid programs. A June 2010 study from GWU finds that the national expansion of health centers -- our expansion will

contribute even higher savings, with expansion of up to 122 billion in total health care costs that would be saved by 2010 and 2015 alone, by the expansion of community health centers from 20 million people served to 40 million people served. An interesting footnote is that there was an international conference two weeks ago in Toronto, Canada, where Western European allies in community health were calling for the expansion of community health centers in their locales as well. Health centers can not rely on billing of public sources for our care, and moving on to our recommendations, we'd like to be specific, and our written testimony provides even further detail.

We have four recommendations to bring forth today. The first, which I think has been discussed in previous forums, is to include primary care investments in the Medicaid waivers program. The fact that the majority of health center patients are publicly funded -- and, by the way, it's 80% on average -- provides the state with an opportunity to seek resources in the state Medicaid waiver, further strengthening the value of health centers and expanding access, reducing costs, recruiting clinicians to low-income neighborhoods, supporting health center-based teaching programs, and improving health outcomes

through enhanced technology. CMS tells us they are well ready to entertain primary care-based initiatives.

The second, to recognize comprehensiveness, effectiveness of community health center care, in developing public pay or reimbursement. As the state moves forward with global payment, the comprehensive needs of health center patients, many of whom experience unstable housing, insufficient support systems, poverty, limited English, low health literacy, and other social and environmental determinants of health that adversely affect their health, must be reflected in fair reimbursement strategies that favor prevention and wellness.

Third, reinvest state resources in primary care as soon as possible, and in public health. Reinvestment in community health center programs and overall public health initiatives is critical to improving the health status of state residents, leading to cost savings within the health care system.

Finally, investments in job creation, creating economic engines, recruitment and retention of providers, community financial stability, health center innovation, and technology produce broad-based savings and leave state policymakers to community health centers. As the state encourages ACO development and

other innovative models of care management, consider supporting of community-based initiatives, where primary care teams in medical homes can demonstrate differentiation in their approach in comparison to institutionalized systems. I'm happy to answer any questions. Thank you.

Seena Perumal Carrington

Thank you, Jim. We'll now hear from Allison Bayer, acting CEO of Cambridge Health Alliance. I want to specially acknowledge Allison for stepping into her new role a week ago (inaudible) serve on this panel. So thank you.

Allison Bayer

Thank you, Seena. Thank you to everybody and the opportunity to testify here today as part of the panel discussion on health resource planning and needs for the 21st century. It's a particularly important topic at this time, as Massachusetts continues planning for a health delivery system and for payment reform, to achieve goals of better health outcomes, a greater focus on wellness, and more cost-effective care. I have five areas I just want to highlight today. Many of these, Cathy Schoen highlighted in her comments earlier.

First, changing the way in which care is organized is core to advancing a more integrated health care delivery system across the medical and mental health continuum, including ambulatory care, acute care, and community-based care. This requires new care models, including the primary care-based, patient-centered medical home, and integrated care networks working as part of a care team to promote health, manage chronic disease, and make health care more seamless and effective for the patient, as well as for the care providers and members of the care team. CHA is innovating in these areas and has made progress, with two of our primary care sites receiving NCQA level three accreditation as patient-centered medical homes last year, and three more in the queue expecting to receive level three accreditation within this year. In addition, we have initiated new integrative care global payment model initiatives, with a subset of our Medicaid, managed care, and Commonwealth Care members, and for frail elders duly eligible for Medicare and Medicaid. Planning for skilled, effective health resources and a new model of care delivery needs to take into account, especially the focus on teamwork and on care management as core elements of this model.

Secondly, as we move to a new model of integrated care, the payment disparities, as highlighted in the recent health care

cost trends reports, profoundly affect the health resources capacity across the state and patient care access to critical services. This is especially true in the area of behavioral health services and oral health services, which has led to gaps in service availability due to chronic underpayments across all payers. The refocus on care with patient at the center is foundational to the goals of payment reform and the structure of financing for the new delivery of care. The movement to accountable care organizations requires new investments in infrastructure, startup requirements, and many providers, especially those of us who serve a disproportionate share of low-income populations, are not positioned to make these investments without new dedicated funding support. Payment reforms are also needed to address documented payment disparities that cannot be the basis for new global payment and accountable care models for the future.

Thirdly, and very importantly, workforce transformation requires robust training and support to the workforce in these new roles and the responsibilities that come with a new model of patient-centered integrated care. At community-based health systems like CHA, approximately 70% of our expenses are for staffing. In our case, 69% of our employees are represented by organized labor, underscoring our partnership going forward in redefining

training and incenting the members of the workforce for new responsibilities as team members, integral to achieving health outcomes and patient satisfaction, and care provision and self-management, as well as satisfaction in terms of employee satisfaction and workforce satisfaction. Planning and engaging in care team development, and new roles and responsibilities that permit health professionals to work at the top of their license while empowering traditional support staff to work as patient navigators, coordinating patient care toward patient self-actualization, is key to health resource planning at this time. CHA has an early experience in piloting and deploying innovations with community health workers and volunteer health advisors as part of the care team, doing health outreach into the community and into patients' homes. To highlight one example of this work, a published study conducted by one of our clinicians, Dr. Karen [Lasser], revealed that same-language patient navigation doubled the completion rate of colorectal cancer screening, and was particularly beneficial for patients whose primary language was other than English.

My fourth point is that information technology is increasingly a core platform for managing and transforming care, and as such, is a core element of health resource planning, both in terms of infrastructure and workforce development. The electronic

medical record is a groundbreaking platform for primary care teams to better manage preventive care and chronic health conditions for their panels of patients. It's also a platform for better coordinating care across providers in the inpatient and outpatient setting, and interoperable medical records and communication protocols across providers who are not in the same health system as the next generation of this work. This is especially true in extending information sharing into community-based settings and the patient's home, where the ability to impact patient health outcomes can equally or more critical than services provided within the walls of a health care provider venue. Finally, patient portals are a (inaudible) means for patients to be involved in their own care, including direct communication with any member of their care team.

A fifth and final area I want to make note of today is the partnership with public health as a cornerstone to wellness. The health care delivery system on its own cannot fix all that ails all of us. Many of the solutions to today's health challenges, including obesity, diabetes, and environmental triggers to asthma, require a collaboration that bridges the traditional divide between public health and a care delivery system. At CHA, we incorporate our work with the Cambridge Public Health Department, in collaboration with state and local

public health departments in community organizations, to advance and improve our population health outcomes. CHA's childhood asthma program, which started nearly 10 years ago, highlights a lot of the points I've covered today. We created a web-based asthma patient registry that contains information about patient conditions, and treatment plan is available not only to CHA's own providers, but with appropriate permissions to public school nurses and community-based health workers as well. This supports parents in their children's asthma management, as we developed online asthma educational resources and tools, including web-based prescription refill requests, and provide home visits by a community health worker and a registered nurse to evaluate asthma triggers in the home environment.

Patient outcomes have significantly improved. Since our baseline in 2001, CHA has reduced annual pediatric asthma-related admissions by 90%, and pediatric asthma-related visits to the emergency department by 65%. Estimates are a saving of $4 for every dollar that we've invested, but because most reimbursements are fee-for-service, and most of the community outreach services are not reimbursed, reducing this service utilization has benefited payers, and absolutely has benefited patients and their families, but does not align reimbursement incentives with a provider to be able to extend these kinds of

innovative care programs across the continuum of services and settings that can meet the integrated health care needs of the patient. Aligning the payment system to support developing these resources, many of which are not reimbursable in today's current payment environment, will be an integral means to achieving the results of good health and high-value care that we all seek. I want to thank everybody again for the opportunity to speak today.

Seena Perumal Carrington

Thank you, Allison. We'll now hear from Julie Pinkham, Executive Director of the Mass Nurses Association.

Julie Pinkham

Thank you for the opportunity to speak with you today regarding the important issue of resource allocation as it pertains to health financing reform policy initiatives currently being contemplated. There are many areas to discuss surrounding this topic, but I'll restrict my comments to focus on just a few key areas of concern. First, I want to address the need for a

robust Determination of Need process to ensure the availability of appropriate services and resources to address the actual health care needs of communities served by the health care system in Massachusetts. This is the very essence of what it means to have health care be accountable. For example, are we accountable as a commonwealth to provide the care that people actually need, where and when they need it? This issue is addressed in the governor's payment reform legislation as resource planning. Secondly, I want to address the workforce development needs for registered nurses to ensure that Massachusetts residents receive the high quality and safe nursing care that they require. Finally, I will provide you with a bedside nurse's view of what deregulation and the unbridled competition has done to the health care system in Massachusetts.

To my first point, any realistic attempt at finance reform must address in a meaningful way the need for appropriately allocated resources. The last 15 years have brought the near complete removal of a meaningful Determination of Need process. One need only to tour the various hospital networks to see the effect of a lack of robust Determination of Need process. The largest budget growth area of hospital expenditures has been capital budgets. Literally, hundreds of millions of health care dollars have been spent in the last decade on extensive building and

technology expansion, supported by millions more in collateral advertising, with no assessment of the actual need of these services by communities these facilities and networks serve. The premise of deregulation, including the removal of a Determination of Need process, was driven by the belief that competition would spur efficiencies, cost reduction, and enhanced quality. In reality, none of this has occurred. Rather, the need to keep up with the competition has spurred institutions to mirror services already available at the same time that market leverage has allowed pricing to increase. More importantly, the services that are expanded are not developed due to a review of need based on public health. Rather, they are expanded based on favorable reimbursement. To many providers and networks, focus on cash cow services and product lines, along with physician recruitment to support those product lines, while other, less profitable programs and services allow stagnant to increasing needs, or worse, are reduced or eliminated. Witness the growth and competition for cancer treatment programs, cardiac surgery programs, and outpatient surgery programs, while mental health beds and behavioral health services are slashed.

It is unrealistic to adopt a market competition business model of health policy and then assign morality to motive. Health care today is a (inaudible) business, and therefore the

desirable goal is profitability and growth. Without a robust Determination of Need process, health providers in a competition model are encouraged to use scarce resource dollars to keep up with the joneses, to compete and survive. If that means abandoning less profitable services, then so be it. By robust, I mean the ability of a state agency to determine the relative need for various kinds of services, the ability to determine whether they can be developed and expanded, and where they should be placed to meet the actual health care needs of the community. That means that in poorer communities hard hit by recession, where unemployment is high and more people are likely to suffer from mental health problems, including substance abuse, we must ensure that there are appropriate and geographically accessible mental health and substance abuse treatment programs. This would also mean that we would not cannibalize and destroy our public health-oriented networks, like Cambridge Health Alliance and Boston Medical Center, but support their growth and development to care for the populations that the other networks have largely abandoned. Given the anemic budgeting of the Department of Public Health in this regard, this review would need to be done in conjunction with the Division of Health Care Finance and Policy oversight. The division’s ability to analyze data in conjunction with the Department of Public Health provides a meaningful approach to

assure that resource allocation occurs in a targeted manner, offering the most beneficial allocation of health dollars to meet the public health needs.

The second topic I would like to briefly touch upon is workforce development, specifically with respect to registered nurses and the nurse practitioners or advanced practice nurses. Given the aging demographics of the United States, the expected need for registered nurses grows sharply as the expected needs of the population increasing age-related health issues also grows sharply. Massachusetts enjoys one of the highest concentrations of registered nurses by population, yet the age of the current nursing population, average age 49, poses a devastating problem. The majority of Massachusetts nurses are baby boomers themselves, and they are at or near retirement. In previous years, the MNA has spent considerable effort highlighting what the literature has so clearly proven that the relationship between registered nurses and patient outcomes in hospitals is inextricably linked. In hospitals today, more patients nurses required to take beyond four in a regular unit, or beyond two in an intensive care setting, results in dramatically increased risk or injury or death. Without a regulatory standard in place, patients receive significantly varied levels of nursing

care across the state, which results in dramatic variations in the quality of care.

The provider industry's opposition to the creation of such [enforceable] standards has vacillated between two key positions: either they cannot afford to hire more nurses, or they cannot find the nurses to hire. Neither argument was ever based in reality or supported by any evidence, yet policymakers have been reluctant to challenge the faulty rationale. Given the current economy, this year the argument is cost, certainly not the ability to find nurses. Indeed, we have waiting lists of students seeking admission to our nursing schools, and we have hundreds of unemployed graduates waiting for the opportunity to enter the job market. For over two decades, I have watched the various health reform initiatives come and go. In each scenario, regardless of the specific reform adopted, the industry moves to cut cost in preparation for expected revenue losses. The target of those cuts is inevitably nurses. But this strategy does not make sense from the point of view of quality care. The only reason you stay in a hospital is for nursing care. If your procedure or treatment did not require 24-7 expertise of a registered nurse, you would be discharged. Today, the only patients staying in a hospital are those who have underlying health issues, making treatment in a more

expedited fashion unsafe. Yet even as patients have far more complex health issues than the patients of a decade ago, the nurse patient load is the same as it was, or heavier, than 10 years ago. With each change, nurses are asked to do more with less, at ever-increasing speed, with no let up in sight. Recently, the number of hospitals have once again began engaging in a serious game of speculation of patient care delivery, suggesting that nurses can take greater loads and non-nurses can begin to do some of the tasks of registered nurses. This deskilling was an avenue of cost reduction attempted by the industry in the mid-90s, and it was a devastating failure. Not only did it reduce the quality of care, it drove nurses from the bedside as they were put in untenable situations. So here we are, 20 years later, and once again, without enforceable staffing standards in place, we see institutions retreating to failed tactics, all in the name of cost containment.

These realities, if not abated, given the demographics of both the current nursing workforce and the citizens they care for, will lead to the worst nursing shortage we have ever seen. The adoption of staffing standards would protect the public interest and allow the state to predict the number of nurses needed to avoid this shortage. Without action, we can expect the nursing enrollment to decrease and nurses to leave the bedside due to

poor working conditions, at the very time when many nurses will be retiring as well. This will happen when the highest concentration of needs for nurses exists. As we look at the resource allocation of the bedside RNs, we also need to look at the expanding advanced practice nurses and nurse practitioners.

Seena Perumal Carrington

Julie, I apologize for interrupting. Do you mind wrapping up your comments, please?

Julie Pinkham

I'll leave it at the nurse practitioners. Nurse practitioners have proven to be excellent providers of (inaudible) care and have been utilized effectively, particularly in areas of the country where physician access was limited or non-existent. Access to primary care can be greatly improved by (inaudible) numbers of nurse practitioners as the population's needs increase. We suffer a similar problem in the area of acute mental health care, where shortage of psychiatrists has resulted in a closure of the number of psychiatric beds. Here again, the

utilization of psychiatric clinical nurse specialists would help alleviate this crisis. I'll stop there.

Seena Perumal Carrington

Thank you. We'll next hear from Veronica Turner, Executive Vice President of SEIU, Local 1199.

Veronica Turner

Thank you for the opportunity to offer these brief remarks and to join this distinguished panel. I am happy to be here today on behalf of 41,000 health care workers of 1199 SEIU, who provide quality care across the Commonwealth. In my remarks, I will focus on issues related to health resource planning, including workforce capacity, training, and the related care access issue. 1199 SEIU membership understands firsthand the need for payment reform. That's why we launched a major Voices of Quality Care public awareness campaign in early April. In addition to (inaudible), we had TV and radio advertising, and forums for both union and nonunion health care workers. We've made it clear that we strongly support efforts to contain the spiraling

cost of health care, achieve required efficiencies, and at the same time, improve the quality of care delivery. We agree that we must slow the rapidly rising costs of health care in order to ensure the success of health care reform and to maintain the financial viability of our health care delivery system. For these reasons, we are deeply committed to advancing payment reform, and are supportive of many aspects of reform proposal currently under consideration, even as we have significant concerns and some suggestions in these areas of workforce, planning, training, and care access issues.

First, 1199 SEIU urges all policymakers to help ensure that payment reform provides a smooth transition to alternative payment models and the creation of a true accountable care organization. Reform must also address Medicaid provider [rings] that today fall far short of the actual cost. Senator Moore, Dr. Gary Gottlieb, and Ellen Zane all mentioned this underpayment as a significant problem for providers. 1199 wholeheartedly agrees with their comments. Medicare rates are unfair to all providers, but particularly to those serving a disproportionate share of low-income patients. They also hurt private insurers who pay higher rates, and the consumers who pay higher premiums to make up for these under-funded Medicaid rates. All payer pricing level, governmental and commercial,

must be considered and adjusted to truly reflect the cost of services, and to stop the current cost shifting of cost for governmental insurance to private insurance rates. Additionally, all stakeholders must come together and address the enormous pressures that may result from and change in reimbursement and delivery models. It would be counterproductive to have low cost and efficient community hospitals close arbitrarily because of growing financial risk, leaving only the larger and better-paid systems surviving. These pressures are already mounting in serious ways, as we are seeing at North Adams Regional Hospital and Quincy Medical Center. Going forward, there should be a needs and readiness assessment to determine what support critical low-cost community providers need to ensure appropriate regional access for all patients.

Second, 1199 SEIU strongly believes that true reform requires the full engagement of the frontline health care workforce. To make care delivering more efficient and to ensure that existing health care workers are able to stay in the field, reform must include support from joint labor management efforts to improve quality, and job reskilling initiative to implement delivery system reform. There is a demonstrated need for training, both for the new health care jobs of the future and multiple procedures and tasks. Ultimately, with the proper provisions,

including payment reform, the existing health care workforce can and should serve as a resource, helping to lower costs and improve quality care. To date, the payment reform discussion has mostly been about the anticipated demand for more primary care providers and experts in information technology. There will be a real need for intensive training of new quality initiative, new care coordination system, and other major system reforms. To this end we have proposed, and a governor's payment reform bill includes an incentive grant program to promote joint labor management quality initiative. 1199 SEIU has a long, proud history and extensive experience in workforce training through our labor management training and upgrading fund. These efforts serve 250,000 employees and 700 institutions in New York, Massachusetts, Maryland, New Jersey, Florida, and Washington, D.C. Labor management training programs have proven to be more successful than other training programs. We believe incentivizing such programs in a final payment reform legislation is essential.

In addition to ensure equitable access across all racial and ethnic communities, payment reform will increase the need for a multicultural workforce. It will require a workforce that is integrated into communities, and providing needed preventative care in order to reduce racial and ethnic disparities. With

some additional training, 1199, entire workforce, hospital, nursing home, and even PCAs, are well-positioned to meet that need. Additionally, the potential to rethink existing programs, such as the personal care attendant program, could help to play a large early warning, prevention, and care coordination workforce in the homes of the disabled and the elderly across the Commonwealth. On Monday, health care financing co-chair, Representative Walsh, made a strong case for the need to think through the job impact of these proposed changes and prepare now for them. 1199 SEIU could not agree more.

Seena Perumal Carrington

Thank you, Veronica. The last remarks will be from John Auerbach, Commissioner of the Department of Public Health.

John Auerbach

Good afternoon, everyone. I'm going to be talking about the role of the Department of Public Health, as well as the Division of Health Care Finance and Policy, as indicated from our historical work, and also the content that's included within the

governor’s payment reform legislation. I thought I would start just by sharing with you some of the changes that have occurred over the last few years in terms of the Determination of Need program, because this illustrates the potential role of the Department and the ability to change and to adapt as a result of new conditions. These four bullets represent changes that have occurred just in the last few years as we’ve looked at some of the new developments, and, for example, the need to ensure that the community hospitals throughout the Commonwealth have the ability to be competitive and survive. We’ve taken on some additional responsibilities within the Determination of Need office in the following areas. I won’t go into those specifically, but can if you like.

However, our capacity to take on new and specific challenges, including the ones that my fellow panelists suggested, is inhibited by the lack of resources. In the 1970s, when we were doing, as a state, health planning on a serious level, we had about 60 people who worked within the department who developed regional and statewide health planning documents that helped to guide the thinking about where the need was in terms of different kinds of facilities and the workforce. That unit of the department, which used to have more than 60 people, now has three. They’re not even all fulltime. They have, obviously, a

lot less capacity to do that work. Those three people work exclusively on the Determination of Need program, and as the additional responsibilities have increased, as indicated by the last slide, we're unable to take on new tasks without additional resources. This is, of course, compounded by the fact that the complexity of the health care environment has changed significantly, is continuing to change, will change, as a result of payment reform as well, and that treatment options are changing very quickly as well, as our keynote speaker indicated.

So within the governor's proposed legislation, there's a section that talks about creating a Division of Health Planning at the Department of Public Health. Among the activities that would take place within that division would be a biannual state health plan. There would be representatives from a number of different state agencies, but other experts as well who would participate in overseeing the development of that plan. Part of what would happen, in addition to looking at the demographics, health trends, treatment patterns as well, it would also come up with some recommendations for the kind of activities that would help in terms of adapting our health care system to meet those needs. Included within that health plan will be the inventory -- minimally, will be an inventory of current health care facilities and assessment of the need for services, compared to

the supply that currently exists, and multiyear projections. Here's some examples of the health planning activities that we anticipate. We would be -- both the Department of Public Health and the Division of Health Care Finance and Policy would be looking at evidence-based practice recommendations regarding indications of positive health outcomes that might be included within the accountable care organization contracts to ensure that the highest quality services are being provided. As a corollary to that, there would be a transparent public database that would make that kind of information accessible to anyone who had interest.

DPH would be looking at a variety of different data sources, including trends in demographics of the population, looking at such things as the age of the population, as well as socioeconomic indicators, transportation indicators as well. We'd be looking at new and emerging patterns of illness, injury and wellness, and we'd be looking at the existing health facilities and clinical practices within the state. The Division of Health Care Finance and Policy would focus its attention on service utilization. It would be continuing the work that it's already doing, but strengthening that with additional staffing and expertise to be able to look, in much greater detail, at the patterns of utilization and the factors associated with

preventable hospitalizations and other types of utilization that we either want to encourage or discourage. The division would also be focused on looking at the medical expenses by geographic region. You saw preliminary information that's gathered on that, but again, the division needs specialized staffing and additional resources in order to meet the detailed needs that will be necessary in order for us to do adequate planning.

Workforce -- you heard from my colleagues on the panel the importance of understanding both what the current workforce actually is, and we don't have very good detailed information about our workforce now. We have inadequate projections about, for example, the number of providers that are actually doing primary care fulltime. We need to develop more sophisticated ways of assessing that kind of detailed information. But we also want to project the health workforce needs. If, for example, we need to expand the number of nurses that are involved in primary care, we're presenting that information ahead of time. When we look at the other workers that are needed in health care and the emerging jobs that will be created, we want to make sure that we're providing people with training and skills necessary in order to take those jobs.

Some of the recommendations that are likely to come out of that kind of a plan, as I mentioned earlier, would be enhanced determination of need processes, but possibly also strengthened efforts with regard to our oversight and licensure, where licensed hospitals, clinics, et cetera, we can insert within the licensure requirements certain kinds of incentives in order to move in particular directions. We also oversee the licensure of health care professionals, and we can look at those regulations to see if we need to adapt those to meet the changing conditions as well. If we thought about what a union might look like, it might look something like this. This is a very general picture of what we would be establishing with the Department of Public Health, but we would have some emphasis on the future, what are the trends, where are we going. We need futurists. We need to understand where we'll be in a few years, and we need to read the literature, look at what other states and countries are doing, and project out. At the same time, we need great clarity and detail about what the present situation is, greater than we're able to gather now in the two agencies that are focused on this. Then we need to think creatively about how we can move in the direction of creating the right incentives.

Let me just say one word, even though my time is up. It would behoove me as the head of the Department of Public Health to

just also mention -- this isn’t part of my presentation, but I do think that the issue of population prevention and its relationship to clinical prevention activities is critically important for us to understand in greater detail. We think that more needs to be done to understand what can be done, what is necessary to create the appropriate incentives in clinical medicine for prevention, what’s necessary in order to ensure we have community-wide prevention activities going on, and we also need to understand that gray area in between, where we can have members of a clinical team, such as community health workers, patient navigators, and other kinds of educators, who, some of the time, may be working with patients in groups or individually, and some of the time may be working at a community level to change the conditions in that level through regulations, zoning changes, et cetera, that are necessary to create healthy conditions within the communities that reinforce the behaviors and incentivize the behaviors that people are being encouraged to adapt in their clinical visits. Thanks.

Seena Perumal Carrington

Thank you, Commissioner.

Cathy Schoen

I guess I have a double role of moderator, which is definitely what I'm doing. There are a few of these cards that seem to be directed at me in terms of a question. Maybe what I'll do is quickly respond to -- and particularly, there were a series of questions about IT and remarks I made about IT -- and then turn to questions that I think are more related to each of your presentations.

On the IT, it's actually a terrific set of questions that have been sent it. I have both -- a lot has been made about electronic medical records. How do you make sure that they're implemented well, and how do you worry about privacy? What are going to be the challenges to implementing IT with integration? Where do you think we're going to be in five years? How effective has it been? I think these are all excellent questions. We are really in the middle of a national experiment, but where we've seen IT integrated within a care system, there's been huge learning and very rapid use about how to learn, but also changing over time. The challenge is going to be when it's not in a well-integrated care system and we start talking about exchanges across sites of care that are

working in different organizations that are not already well-organized, working with each other. We've already seen hospital physician kinds of transmissions of information get clogged up with the amount of detail and doing that well. So I think there is a learning curve on this. The national effort to spend the money that was put in the stimulus bill is going to give us insights as different communities start to build IT hubs. The privacy issues are certainly there, but one of the things we've seen with care systems such as the VA, which has had a record system for a while, is it's not clear that our paper record systems were ever very well protected. With patients' permission, the minimum amount of information that gets transmitted out seems to have been fairly well protected. Again, this is an area where we're learning rapidly.

We have somewhat of an advantage in the U.S. of lagging behind some of the other countries that have done this, because we can watch both from their mistakes, but how they tackle different issues as they came up. This effective use and effective implementation is a major issue. I'll just give an example from New Zealand, which is integrated in multiple flows. They found that the electronic transmissions were coming, including from labs, but the physicians didn't always know they had arrived. How do you build alert systems that there's information? How do

you use it? Kaiser is discovering, with electronic visits, questions that are coming in, that physicians have their day job when they're seeing patients, and then back at their office is 50 or 60 emails from patients, and how can they make sure they're responding well to those and not missing something, and how can they use people to be looking through those. I think it's definitely a learning exercise, but what we've seen is these creative breakthroughs when maybe are working well, including just basic information, that, when you're out of an office, you can get information. The digital records -- digital -- using resources as well.

In New York, with the Health and Community Hospital Corporation, which is the public hospital, they have a scarcity of specialists within their system. They were able to digitally read some of the results of tests and decide whether to come in or not, based on it's serious, I can see it, or it's not. It's a different way of having virtual systems and teams. That's where we don't know the full potential, but we're just starting to see it. You have pretty well integrated systems, IT systems, in several Massachusetts provider systems. Getting those systems to talk to each other is one of the issues that the IT office federally has gone through, and there are some standards and protocols that not all information is transmitted, but

critical. I think there isn’t a definitive -- this is exactly how you implement it, but it has to be used well and used within a system that is valuing that information flow.

I don’t know whether any of the panelists have specific comments to make. I know Cambridge Health Alliance has a very robust system, so you might talk about some of these issues.

Allison Bayer

We do have a very strong electronic health record platform, which we rolled out starting about eight years ago, across all of our ambulatory sites. We do about 700,000 ambulatory visits a year in our system. We do have the advantage of having an employed group of providers. All providers in our system are able to access the information. One of the issues, I think, or one of the benefits of this, is that, from a patient safety perspective, our ability to do medication reconciliation when the patient presents whether they see their primary care team member, whether they go to a specialist, or especially when they show up in the emergency department, any one of those providers has the ability to see what the meds are that the patient is on and to verify that before they proceed with prescribing or doing

an intervention that may or may not be appropriate. I think the second thing for us with that is that, in terms of workforce development and working at the top of the license, we've implemented -- we do have an outpatient pharmacy for some of our patients, and the ability of a patient in our system to call in for a prescription renewal, to have that information taken by a member of the care team at the primary care site, to send a message electronically to the pharmacy tech in the pharmacy, who can look at the med issues, frankly get the payer authorizations if that's needed, check with the pharmacy benefit manager, send a message back electronically to the physician that it's OK to renew, or if there are questions, to raise that so the appropriate provider on the care team can get back to the patient, including the nurse, who can do appropriate education and teaching with the patient about a new med. So for us, it's really been about patient safety and about improving the workflow for the patient and the care team taking care of the patient.

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Can I ask a question? It seems like a lot of the innovations that you've discussed, including the VA model, come in systems

that have -- industrialized countries that have single-payer systems or public health ministries oversight.

Cathy Schoen

It depends on which country you look at. Actually, the comment about you've seen one CHC, you've seen one -- the countries have brought these systems in quite differently. In some cases, they've done very much what we've done. The Denmark system, or the Dutch system, it's private practice practitioners. There was a lot of leeway on which software, what you brought in, but there was some standardization on being able to talk to each other and having at least some capacity. The U.K. system is an integrated -- much more like Kaiser, bringing it all in at once. Different systems have brought in some but not all components. We probably will be ahead of some of the other countries in the kinds of smart record systems, if they work, because it has more decision support built into it, but the decision support modules need to be constantly updated. You know, on early alerts on medication, new clinical guidelines. So there's a background that feeds into a smart system, where it's decision support as guidelines change. Most of the other countries have much more of an electronic communication feature to them than a decision

support, so at least knowing all the medicines your patient is on, whether you prescribe them or not, and the pharmacist being able to give you an alert -- not a good idea, wrong dose, not good for an 80-year-old -- those kinds of communicating back and forth. I think that's one of the things that's interesting, that countries have brought in the systems differently. People are saying, if you have that, you can get very far. What are the barriers, and then, as groups, start to work on them.

James W. Hunt, Jr.

Just a very quick comment. It can also work from a patchwork perspective. We set a goal at the league in -- I guess it was 2007 or 8 -- to create an EHR platform for every health center in Massachusetts, either through hospital-based systems that were aligned with us, or through public support dollars from the Commonwealth, capacity-building dollars made possible by Chapter 58, and private donations, including hospital donations. I'm here to tell you, we've gone from 17 to 49 to 52, with at least some form of an EHR platform. But that's only the beginning. Back to the waiver again, it is our position that CMS and others are very interested in Massachusetts as a place to perform the experiments that will be necessary around creating real

interoperability in health center control systems, in hospital-based systems, hospital community systems, et cetera. Frankly, those kinds of dollars are not going to be made possibly by add-ons from CMS, or from the patient-centered medical home, or, frankly, from the CMS initiatives. Getting from here to there in Massachusetts, for community hospitals, public hospitals, and community health centers, is going to take some forward-looking innovation funding that can possibly be made possible through the waiver.

One other final point. We're going to the next phase now, where we've created a data warehouse platform with private donations. We put about $7 million into our product. It's called CHIA DRVS. We have seven health centers up on it. Rather than waiting for Medicaid information three months to a year down the road, or waiting for what we call UDS data a year down the road from the federal government, from these seven health centers, we can extract 20 pieces of vital outcome-measured information daily. Doc to doc, health center to health center, practice site to practice site, daily, within the hour.

Cathy Schoen

I want to move -- I opened a big door when I mentioned IT, so I'm going to move off that. I have actually two related questions that are directly related to Determination of Need and the extent to which it's both going to be successful going forward, about restraining growth where there's no real added value of excess capacity, or being able to think about where do we need to downsize and do we need to leave some community capacity. It's two questions: what role do you think Determination of Need is placing the future, and how well do you think it's working? I guess both the panelists -- are we getting what we need out of it or not, and what kinds of changes might it need? I might just say one word about this, just from my perspective as an economist. If part of the reason we've got an expansion is that there's a huge marketplace for it, you can make money and it's a margin, sometimes behind that is examining the level at what we're paying and the way we're paying. Not trying to just regulate it. Japan completely pushed down the price of an MRI and a machine and got innovation out of it by just being tough. I guess I would say, to what extent is payment part of the thinking as DON goes forward?

John Auerbach

I think that we should think creatively about DON and the way that it should work, and I don't think we should be limited by the way that it's worked in the past. Clearly, the way that it works now is it becomes a barrier to entry into certain types of activities. That can be restricting unnecessary building. It can be making sure that we don't have excess technology. That is how it functions now. It does not creative positive incentives for providers to go into particular arenas currently. It could. We would have to think creatively. To give you some sense of where we have thought creatively that has changed the rules -- oh gosh, I think it's maybe almost 20 years ago we created the notion of community initiatives as a part of capital projects. There, the idea is about 4% of the cost of a capital project now has to be allocated towards community-driven population-wide activities. In most instances, they're population-wide. That was new. It hadn't been done before. Now it's part of the process, and it's created tens of millions of dollars in a variety of different activities as a result. We can change those rules. It does require thinking it through very carefully. We also have to, I think, avoid the danger of becoming a barrier to necessary service development. Currently, I think, the lack of staffing means that the approval process is

a slow one. There are times when we don't want it to be a slow one. We want review to be done quickly, and we want decisions to be made in a timely manner. So I think even in terms of the barrier function that it currently has now, we need to streamline that so that when we don't want to be a barrier, we just want a quick review to make sure we're consistent with where the need is, we can get through approval processes quickly and we can tinker with them or create matching incentives if we want approval, but only if that's paired with another kind of service, for example.

Cathy Schoen

I have a question that's directed toward community health centers. Should community health centers start thinking about expanding their patient mix by attracting patients covered by commercial health plans? Stay within the traditional mix. To what extent are there barriers to doing that? I'll just put it in -- I know there's some concern about the Medicare ACO regs that community health centers, the way they allocate patients, that they're not likely to be one of the primary care bases. Expanding -- when I look at the mix, it's not just commercially insured, but it's fairly low rates of Medicare patients as well.

James W. Hunt, Jr.

Let me see if I can answer it quickly. I'll put it in two parts. First, there are about 88 comments saying to CMS, why exclude community health centers from the Medicare regs? So that's yet to be seen. Thankfully, Dr. Bigby has at least stated to date that the Medicare reg will not be the standard for the Medicaid reg here in this state, so we're very grateful for that and responding to CMS, who has said you can't play because we don't have the baseline data for you, or benchmarking data for you. Hopefully, they'll see the light that health centers can play.

With regard to community health centers expanding into other populations, I call your attention to Frederica Williams' testimony, from Whittier Street Health Center, that is online, that speaks to 90% of her patient population being publicly supported. But what's interesting about that -- if you've seen one health center, you've seen one health center. She's got a mix of Commonwealth Care, uninsured, and Medicaid recipients in her practice, and a very small commercial base. Other health centers have grown in the commercial space, particularly in our

Commonwealth Care product, and more recently in the Commonwealth Choice product. In the last three years -- the first three years of health care reform, give or take a breadbox, we saw and experienced 114,000 new patients in our community health centers in Massachusetts, according to the Kaiser study. What's interesting about that, and what is not really seen, is that some of the patients that move from Medicaid to Comm Care, and then hopefully to Comm Choice or into private insurance, are the same patients. They're moving in those streams. They're covered, to the 98.7 percentile, but they're moving in those streams. Getting at us being the medical home for those patients, regardless of the source of coverage, is a very important factor for us.

Having said that, we are really interested in growing the commercial base. Two of the four health plans, I believe, that currently occupy most of the Medicaid space, Boston Health Net and Neighborhood Health Plan, both have commercial. Does Cambridge Network Health have commercial now? Yeah, but it may in the future have commercial as well. So all the plans seem to recognize that potential growth into the commercial space. In Neighborhood Health Plan's case, I can just tell you that the commercial product for Neighborhood Health Plan has grown dramatically in the last couple of years. I can't really speak

to Boston Medical Center, because I think they're just entering into that space and recognizing it. I think all the plans, and the health centers specifically, see the commercial patient as a future and important cog in serving the patients that reach your doors in that community that you choose to serve.

Finally, and probably most importantly, as the baby boomers age, we're seeing the health centers begin to reflect that. We have health centers that have started PACE programs and have elder service plans, and moving more toward the specialty Medicare beneficiary. We at the league hope that all health centers will begin to try to serve more of the reflection of their communities as those populations age. Maybe somebody else has a comment as well.

Cathy Schoen

I have one directly for nurses, and particularly the MNA. The MNA is pushing for a nurse-to-patient ratio in all your contracts, despite the fact that this appears to inhibit hospital efforts to reduce health care costs. How do you suppose that hospitals can cut sky-rocketing health care costs? It's an issue of fixed ratios.

Julie Pinkham

I'd like to believe that we are putting them in every single contract, but that's not true. Nonetheless, why it's coming to the contract is because nurses, as contracts opening, it's not being dealt with from a health policy perspective. When they have changing work conditions, the only last resort they have to deal with the issue is through their collective bargaining. That's why we're seeing this happen. If we had had a policy initiative, we wouldn't be addressing it through collective bargaining, which we actually think is probably not the best method to do it, because what happens is it exacerbates the problem on quality based on leverage, which is exactly what we're seeing in the marketplace approach, that we have competition. If we have a small hospital that there's a movement to change the staffing ratio to one that we think is unsafe, and nurses will be forced to put it on the table, potentially to a strike situation, how much leverage potentially will 200 nurses have versus 2,000? So therefore the quality of care delivered at the institution with 2,000 unionized nurses will be better than the institution with 200, potentially. It's the exact reason why we don't think they should be handled this way, but left with no other ability to do so, nurses will not sit by and watch staffing change to manners that are incredibly

unsafe. There's just a plethora of data at this point that clearly shows that the number of patients nurses are taking is directly linked to quality outcomes.

I think that what has been lacking in the discussion is the recognition by having appropriate nursing care, we actually diminish cost as well by reducing length of stay, reducing recidivism, reducing med errors. All of these things have a side benefit of appropriate care, which I think should be valued, but since they don't seem to be placed a value on them, we're seeing that the quickest cut you can do is a labor cut, and so we tend to go back to the -- as I said before, this is exactly what was done in the 90s. It failed abysmally. It caused one of the worst shortages that we've had, and then, ironically, when we came back to the collective bargaining table, there was a recognition of need to get nurses back into the institution, and that resulted in double-digit inflationary wage increases. How amazing is this, that the union is sitting here telling you that we would much prefer to not have the leverage for the double-digit wage increases and have appropriate staffing instead? I think that would keep nurses at the bedside. It will draw nurses back to the bedside that have left, unfortunately. And if we don't do it, we are going to see what is one of the worst nursing shortages that we have ever

seen in my lifetime. Because, right now, we did a lot of effort getting supply up, knowing that we have baby boomers that were coming up and the need for healthcare in the demographics was going to be very high.

If you look at the 90s -- and I'll stop after this, because I could definitely go on on this -- if you look at the 90s, when there was the first round of deskilling approach after market deregulation, that's when we had the first round of mergers. There was a number -- it was essentially a freeze on the positions in nursing. There was an attempt at deskilling. The wholesale sort of deterioration of the working conditions resulted in really unfavorable circumstances for nurses, by which, when they had the opportunity to reduce hours or leave, they did so. So when we look at our actual seniority list of nurses, we can see that we have top-end seniority, because what happens when you have a layoff is, under collective bargain agreement, the senior nurses will be retained. Then there's a big hole for seven years, and then there's the pickup of the registered nurses being hired back after the failure of the plan. If you take that hole and you proceed forward towards retirement, which is the baby boomer nurses themselves, couple that with the demographic increase of need based on the population, you're about to hit one of the worst shortages we've

ever seen. Our hope was that, by having the new nurses supply increase, and the hiring of nurses now, we'd have an opportunity to mentor nurses for the next five years or so, so that when the drop-off occurred of registered nurses at the top of the scale, we would be well-positioned to have expert nurses at the bedside. That (inaudible) has shut off. Nurses are not being hired. We are seeing layoffs. We are seeing deskilling. All the things that are the recipe for disaster, once again. I always thought that if you understood your history, you were not going to repeat it, but in this particular instance, it does not seem to be the case.

Cathy Schoen

This is also a labor cost issue, but a broader set of questions. If we really succeed in bringing down costs of care and we think about working in innovative ways, which would be a reduced use of the hospital, more use of community-based care, won't it have some negative effect on labor, or aren't we talking about potential job loss? Fewer slots. How do we think about those issues? Particularly 1199, in terms of sort of a maintenance of effort and a protection of jobs, are there fewer jobs, or is it an issue of the location of the jobs will be shifting?

Veronica Turner

I think probably both. There will probably be less jobs in acute care facilities, and a potential to have more jobs in the community and at community health centers, which is why we're focusing on retraining the workforce so that they meet those needs.

Cathy Schoen

I have -- I'm trying to figure out -- some of these are related. So those two were the general observation of reducing the labor supply. I might just make a note on what we've seen in terms of some of the innovative work, even within hospitals, in terms of new ways of working together. Denver Health Hospital is an example where the nurses were asked, are there any parts of the day where you're wasting your time, and can we give you time back? One of the things they said, we spend a lot of time trying to find doctors and get attention and get them to feed back, and we can't use loudspeaker systems. They invented a little lapel piece where they can talk to each other. They got

a huge amount of hours back and started staffing in different ways, but I think what we're starting to see is some of the work process, reinventing the way we work in hospitals. Have started to be able to get where we're wasting people's time out and use it more productively. I don't know where we'll go with that, because that information doesn't flow out very easily. The places that have done that are actively working on it, but this sort of configuration on what's the right staffing, it's a different kind of staffing for sure.

There's, how do you feel about excess capacity? Do we need -- Harold Miller talked to me a little bit about the remarks he made earlier. If we've got some underused low value in places with specialty care, should we let them close? If we let them close, what do we do about emergent and urgent care? Do we create an access problem? How do we think on where we're -- we've got capacity but we're not using it well. Do you maintain some excess capacity deliberately or not, is, I think, the essence of this question. I guess I'd throw it up to anybody. It's not excess capacity as much as, we've got a low volume use of a high specialty, and we know it would be better if it was high. Do we just let that unit go away? Do we let the beds go away?

Allison Bayer

I think that's a tough question, and I think it's tied to so many components that we've talked about. I think Julie and probably Veronica mentioned it, too. Sort of the example I talked about with our pediatric asthma initiative -- ironically, what happened by creating new means of managing patients with asthma, reaching out into communities, engaging various members of the care team, including community health workers and nurses and physicians -- school nurses, especially -- being better able to manage asthma care for our particular cohort of patients meant that it reduced the need for our inpatient pediatric unit. As a community hospital, children who needed inpatient care, that was at a significantly higher tertiary level of care. We weren't providing that. What we found was, more and more, the patients who were utilizing our inpatient pediatric beds were actually as a result of asthma. So as we improved the way asthma management was done and delivered, and improved the health outcomes with those patients, we didn't need that service as much. We were actually dinged by that in the way the reimbursement system works, because we had, in that case, quote, unquote, "excess capacity." Also, it was a service that wasn't particularly well reimbursed for us either, being a safety net

institution. The question becomes, what is excess capacity as you actually improve health outcomes that change the way you deliver care, and how do you retool that to something where there is demand and there is need, in some cases? The current reimbursement system, which sort of historically undervalues primary care, mental health care, and other services that end up going away when there is demand, is sort of the flipside of, what do you do if you have need for high-cost specialty services and low demand -- what's the driver for a decision that you keep one, or reduce it, or exchange it for another? The geography in which any service sits obviously complicates the question. The answer in Greater Boston may not be the answer in the Berkshires.

John Auerbach

My inclination would be to say there's not a uniform answer to that kind of question. I think what you're talking about in terms of excess capacity is where we need a -- if you're talking about where we need a service, but where utilization is not operating at the highest level of efficiency because occupancy levels are lower than the optimal level. If that's the case, I think we need to look at it on a case-by-case basis. We've

seen, for example, uniformly, that when we've looked at rural hospitals, we've had to make exceptions with regard to the optimal levels of efficiency, because the rural areas simply don't have the population density that others do. There's been a combination of that at the federal level, as well as at state levels, and I think that that should be factored into calculations around reimbursement. We have also seen that there are sometimes very much needed services, and here I'll use the example of some of the inpatient psych beds, where the utilization of those beds may be lower than the ideal amount necessary to maximize revenue for a unit, given staffing requirements. We can't afford to lose the service, even in those circumstances, because patients would have to travel too far for the service, and it's considered one that's essential in terms of community health. There, I think we need creative solutions, and I don't think we have at our fingertips all the right ways to do that. Some of the solutions, I think, are maybe related to payment reform. Other solutions, there may be other creative approaches. I think you've suggested that there's a variety of different approaches, and where we can come up with innovative ways to meet the need without using the traditional models we should. Obviously, inpatient is not -- telemedicine doesn't work for inpatient care, but there are some

instances where thinking creatively and being on the cutting edge in terms of trying new models makes sense.

Julie Pinkham

I would say this much: it should be more than simply the market. We need a public health assessment. That has not been given a level of value that it needs to be given in order to make the decision. If we leave it simply to the market, I think, at the end of the day, it has not proven effective.

James W. Hunt, Jr.

Just a very quick comment that's a little off-point, but I think it makes a point that hasn't been made. That is that some of the capacity is being used to filter through and to extend other capacity. A model is Cambridge Health Alliance and how it trains its physicians in community-based rotations. They wind up in community health centers, which is a big plus for primary care. The same is true of one of our health centers, at Family Health Center in Worcester. Seventy-five percent of the folks that train there, in fact, wind up being placed in a community

health center. Greater Lawrence Health Center, the same thing. You have a hospital that basically has its community-based health centers training its physicians. They wind up in health centers. By just evaluating the particular unit inside the hospital, it doesn't really tell the whole story, so back to Julie's point of more health planning and looking at these things very carefully before we start chopping away.

Cathy Schoen

I have a question on the way health professionals are paid. Since most health care professionals are salary, do you think that physicians -- if physicians were also salary, would it help on containing health care costs?

Julie Pinkham

I think this goes less than salary at an hourly, in terms of thinking more employed versus not employed. That's, I think, closer to the question. I think if we were looking at a global budget system, then employment status is a very different issue, and I guess I would say appropriate. The clinician's role is

different. The employment status, and therefore salary status of employment. The dynamic is different in decision making. I will tell you a fear that I have is that, under the ACO, or global payment -- expanded capitated payment is more how I look at this right now. I am concerned that as physicians move into employment salaried status in that, their clinical advocacy of patients, their ability to voice that, may be diminished in a manner that's not necessarily in the patient's best interest. I think that's of concern to me. Again, if you had a global budget, then I'm not so concerned about that, but when you have competitive networks in which a physician is actually an employee within the network, potentially under contract arrangement and what can and cannot be articulated, I think that is a real struggle in the relationship of an MD and their license. Now, for nurses, less of an issue, because, to be honest, we're unionized. That is how we will get our voice. You lose your free speech when you walk through the door, but you gain it through unionization. If you're a physician, you have a tremendous amount of control right now, because if you take your practice and your group and you walk down the street elsewhere, and you have the ability to refer a patient to an institution, that's a lot of leverage. If you no longer have that leverage, I guess that's the piece that concerns me. I guess, philosophically, employed status salary, I think, is

good, and under a single-payer status, it would be wonderful. I see that as a more beneficial future. But under this limited cost arrangement, I'm a little nervous that the tradeoff for the physician group might be a lessening of their voice in terms of articulating care needs. I don't know how you balance that to assure that the patient -- we need all of the stakeholder voices to be as equally loud --

Cathy Schoen

I think that's part of -- just to give you a partial reaction, I think that's definitely been part of the both federal discussion, but I think you're having it now on requests for information, response on accountable care organizations. What are the metrics that operate outside that to start to keep the care system accountable, which would partly give voice to patients, partly give others? Where would we need to know that things aren't moving in a positive direction?

Allison Bayer

I would also say, however, that under the current reimbursement model for physicians and private practice, and depending on what specialty they are, the incentive is actually not necessarily always about the patient outcome. It's about the volume of charges and the volume of work being done, because that's where the reimbursement comes from. We do have a largely employed physician practice at our organization. Not 100%, but very significant. Ninety-five plus percent. Our ability, actually, to attract physicians, especially primary care physicians and mental health clinicians who are clear advocates for our patients, has actually increased as we have started to move to a medical home model of care. We had no problem -- knock on wood -- attracting and hiring high-quality primary care physicians who wanted to practice at Cambridge Health Alliance because they wanted to practice in this model of care with a care team, and working with our patients. The incentives that were specifically around how many patients you saw, and therefore that translated into something in your paycheck, was removed. Incentives were changed so that it was really around panel management, panel health statistics, team-related outcomes, and team goals that were set. To Jim's point, we do train a lot of primary care physicians and mental health physicians and

clinicians, and they do like to practice in these systems. In fact, it's becoming easier for us to recruit. In the old days, I think it was harder for us to recruit.

The potential movement to global budgets and ACOs -- I've talked to a lot of specialists who have a great concern about that. What does that mean for me? What does that mean for my income generation? I think what we're trying to do, in our journey around this, is say that, as we manage population and manage panels of patients, if we change the incentives and make the incentives such that it's being clinicians and all members of the team are incented for the outcomes of the patient, around the outcomes of the patient, and not on purely the paycheck of the individual, it really changes the name of the game.

Cathy Schoen

I've gotten a sign that we're down to about five minutes left, so I have a second part of a question on community health centers that were specific to your reference to a global fee, a global payment. The question was, how does that really differ from the way you're paid now, particularly as an FQHC? Maybe you could explain the current way you're paying and how this

would be different. What would you mean by a global payment and how is it different?

James W. Hunt, Jr.

First of all, we've enjoyed a relationship with the division back to 1978, where we opted, as a movement, as a community health center movement in Massachusetts, to opt out of the cost-based reimbursement system and move into a rate-setting system, where we've remained ever since. Through the division, health centers receive return on their cost, based upon a cost report that's filed annually and reviewed every two years. Nationally, that's not the case. We have a prospective payment system where health centers enjoy a wraparound based upon federal law, that, whatever the health centers costs are, the state will pay its share, and then whatever the additional cost is, the state will pay that share on a wraparound payment to the health center. That does not occur in Massachusetts. We've accepted, if you will, a fee-for-service payment. Back to what Allison alluded to, this movement from volume to value basically takes those community health center visits and moves them into a potential global payment structure that would reward with incentives the value rather than the volume. Currently, we're paid on volume.

We would hope that in the future, we would -- that's why we've embraced the reform efforts to move toward a value-based system. We've been providing services through our physicians and nurses and health care workers for now 45 years on salaries. When Allison mentioned the old days, I just chuckled, because in the old days, we were thought to be the outlier, because we paid our staff and they didn't have to earn. But of course they did, because serving in mission-driven setting with a very, very hard mix of patients, with multilingual, multicultural capacity, was not easy. Today, we value the mission-drive physician, but we also recognize that the nurse practitioner and the nurse and the care team and the coworkers have lives, too, so we need to formulate systems of payment for our physicians and our teams that are reflective of the marketplace, and not lose our physicians and nurse practitioners and others for the pricing that's going on in the marketplace. On top of those salaries, we're trying to create incentive-based, value-based propositions that would reward the whole team. A couple of our health centers have been extremely successful at it.

Cathy Schoen

I'm just looking to make sure I've captured the questions that we've received. There are a couple more global questions. One is, given that innovative care coordination requires links between traditionally fragmented providers, what links should be the highest priority for development in order to achieve integration? Particularly for those of you who aren't linked up. I think it's a question of where do we start, or are there building blocks in places to start. I just would add to that, what do you see as the role of public health agencies in promoting health and preventing disease, and to what extent should they be more integrated? A two-part, thinking in part of the silos that we're trying to link up. Where do you start? What should be the top priorities? Where does public health play a role?

John Auerbach

I'm happy to jump in on public health. The aspect of public health that I think I would focus on the most is what I referenced earlier, and that is that we need to establish incentives, I would argue, within payment reform, to think about

ways of linking the clinical providers to the activities that are taking place at a community level to make it more likely that patients are going to be able to adopt, or healthy behaviors, or that the easy behaviors will be the healthy behaviors. There also is, as I mentioned earlier, what I think might be referred to as a gray area, where we may have community health workers, patient navigators, people who are involved in running, smoking cessation programs, or chronic disease self-management programs, who really transcend the clinical community health models and are important for us to value, recognize their importance in terms of both arenas, and then realistically think about how they're going to get paid for. To a certain degree, I would say, as much as possible, we should have that gray area paid for within the payment reform models, but it may not always be realistic, in part because some of those individuals may serve multiple ACOs. You could conceivably have a chronic disease self-management training program or educational activities that are about behavior change that are shared by different ACOs.

There also are certain of the activities that we're talking about that might be clinically based for 75% of the time, but we need them 25% of the time to be going to community meetings to change zoning rules, or work around violence prevention, or

bring a farmer's market into a neighborhood. I guess I would say we absolutely need to work on integration, but integration doesn't mean that all of those activities need to be paid for out of the payment reform approach, but they have to be paid for somehow. We need to talk about what's realistic to include in payment reform, what kind of incentives can we have to make sure that those activities take place, and where it's not realistic for us to have them covered by payment reform, and we need to have them take place. We need to determine how to best fund them. That may be through robust public health activities at the local state level, or it may be through other innovative approaches, and a number of those innovative approaches regarding, should certain activities be assessed in order to help pay for those efforts. Those models, I think, we haven't figured out yet, but we have to make sure that when we're finished, we've got the linkages that are appropriate between clinical care and community health.

Cathy Schoen

Does anyone else have any thoughts on priorities on where to start if you're not already a well-integrated group?

Allison Bayer

I would agree with what the Commissioner said, but I also think that as the momentum seems to continue to grow towards ACOs, there will be multiple ways for different care entities to make relationships. Part of what we've tried to do is to understand our panel of patients in each of our enrolled practices, whether it's a hospital-based or a community-based primary care practice, and to understand what our patients' needs are in terms of the kinds of chronic diseases that they have, the kinds of social needs that they have. Some of the linkages that we are starting to explore for our patient population have to do with community-based mental health providers, so we have a very large mental health service at Cambridge Health Alliance, but we cannot provide everything for all of our patients. Our ability to link with a community-based mental health provider who can provide crisis services in the community, intervention in the home, and so forth are critical linkages for us to consider for our patient population and how we can better manage them and improve their health outcomes and their care. That's an example, but I think it's driven from knowing who your patients are and knowing what they need and how to improve their outcomes. Putting that in the context of the payment reform

environment is a significant strategic effort. It's not just a tactical effort.

Cathy Schoen

We just got the stop sign. I want to thank the panel for being very responsive, and I actually want to thank the audience for terrific questions. I hope when I combined them, I didn't lose the essence of some that seemed to be different aspects of a similar question. Thank you very much.

Seena Perumal Carrington

Thank you panelists, again, and thank you Cathy. I just want to quickly recap some of the highlights of what I think I heard today. Let's begin with the morning session. Harold Miller performed an impressive feat, and that being somehow synthesizing and summarizing payment reform models into a 30-minute presentation. That [slide], by the way, is available on our website, and I find it incredibly informative. Then the ensuing lively panel discussion we had afterwards unanimously agreed that global payments should be the predominant method of

payment in the Commonwealth within five to 10 years. However, they noted a number of different challenges confronting us as we transition to global payments, such as the ability of providers to manage performance risk, and the need for oversight that encourages trust. Similarly, there were differences in opinion on the role of government and market in ensuring and facilitating this transition. Ultimately, Harold and the panel noted that payment reform is necessary, but not sufficient, to tackling rising costs. As a side, we heard that yesterday also, in the consumer and employer panel, that transparency of quality and cost data is necessary but not sufficient. That seems to be a theme that we need comprehensive changes, and there is no easy solve to this problem.

This afternoon, we talked about the need for enhanced health resource planning. Cathy Schoen talked about the need for a whole system view. That theme, once again, of sort of no single solve, we need more comprehensive change, keeps reemerging. From the panelists, we heard about some of the investments needed -- public health, infrastructure, IT, workforce, et cetera -- to meet the demands of greater integration, as well as proposed roles for our agencies in the governor’s bill.

Tomorrow, we're going to shift our focus and talk about yet another challenge confronting the delivery system, and that is the need for greater care coordination and integration. After three and a half days of talking about rising health care costs, and the various factors that lead to those rising costs -- so by that point, it would be increasing prices for services, a fee-for-service payment system, the lack of comprehensive health resource planning, and the challenges with care coordination -- we're going to conclude the 2011 hearings by taking on the elephant in the room, and that is, what is the role of government and market in actually reducing costs? Every panel sort of danced around that issue, and no panel seemed to have unanimous agreement on what that proper role should be. Is it market innovation? It is government intervention? It is parameters set by government? Is it benchmarks set? Do we wait and see? Do we act now? All of that will be tackled tomorrow afternoon, hopefully. Tomorrow, at 9 A.M. --

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